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ARMY MEDICINE

AND

THE LAW

Colonel Maurice Levin, JAGC

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## PREFACE

This Handbook is based upon articles written by the author, and published in various magazines or journals. In order to present the material in a cohesive manner, some of the articles have been slightly revised, and previously unpublished transitional material has been added.

Thanks are given to the following for permission to use indicated articles as a basis for this handbook:

1. Commerce Clearing House, Inc. (The Insurance Law Journal):
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3. Military Law Review:

Incompatible Blood Transfusions (1964).
4. The Police Chief:
  - a. The Medicolegal Autopsy and the Police (1964).
  - b. Lie-Detectors Can Lie! (1964).

I also give thanks to Colonel Laurence A. Potter, M.C., who was always encouraging, to Colonel Frederic J. Hughes, Jr., M.C., who, with his staff, is responsible for most of the professional medical review attendant on clearing the mentioned articles for publication, and to my secretary, Mrs. Antonette Nashwinter, who gave so unstintingly of her time to type the manuscript.

Colonel Maurice Levin, JAGC  
Washington D.C.  
10 June 1964

(NOTE: As of this date, not all articles mentioned have been published. Also, consent to publish in this handbook -- if it is to be published -- should be obtained from C.C.H. and Military Medicine. M.L.)

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ARMY MEDICINE

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CHAPTER I

INTRODUCTION

1. Scope of Handbook. This handbook discusses some of the medicolegal problems that may arise when the United States Army Medical Service renders medical care to patients in Army medical facilities. Problems include the possibility of claims against the federal government or against individual officers and employees of the Army Medical Service for damages for death or injury to patients as a result of malpractice, (1) assault and battery, false imprisonment, libel and slander, and other wrongful acts. (2)

From the standpoint of the federal government's liability for damages, only claims based upon alleged malpractice are of urgency, because the government may not be held liable for damages resulting from the other acts mentioned. (3)

From the standpoint of liability for damages of an individual Army medical officer or employee, all of the mentioned acts are of interest, <sup>as</sup> the law of individual liability is unsettled in this area. The weight of opinion is, however, that an Army medical officer or employee may be held liable in damages, individually, for injury or death to a patient as a result of any of the acts named, if they occur in connection with his rendering <sup>of</sup> medical care to a patient in Army medical <sup>treatment</sup> facilities. (4)

Government and individual liability will be discussed from the standpoint of the law applicable in the geographical areas included within the coverage

of the Federal Tort Claims Act. (5) Basically, these areas are found within the United States. (6)

2. Definitions. In referring to the acts of individual medical officers and employees, the word "physicians" will usually be used in the text as an all-inclusive word to describe practitioners of the healing arts, unless another designation is required by the context. This will be done in the interest of simplicity of presentation. It is emphasized, however, that most of the principles applicable to physicians are also applicable to other medical persons such as dentists, (7) nurses, (8) and laboratory technicians. (9)

The word "tort" is applied to a number of different types of civil wrongs for which a court of law will award damages. (10) These wrongs involve injury to the legally protected rights of people when caused by the legally unacceptable actions of others. This is a circuitous definition which suffers from brevity, but it may be clarified by pointing out that the acts mentioned in the opening paragraph of the preceding section are known as torts. Furthermore, a tort is not a breach of contract.

A contract is a promise or a set of promises for the breach of which the law gives a remedy, or the performance of which the law in some way recognizes as a duty. The promises may be <sup>made</sup> ready orally or in writing in specific terms, in which event they create an "express contract". On the other hand, even in the absence of express promises, the acts or conduct of the parties may be such that the courts will imply the existence of an "implied contract". Not all promises or agreements result in contracts, because some of them, such as an agreement to perform a criminal abortion, cannot be enforced in court.

In civilian life, either express or implied contracts may arise out

of the physician-patient relationship: a civilian physician and patient may agree as to the scope and extent of medical care, and there is then an implication that the patient will pay for the care at a reasonable rate, if the charge is not specifically agreed upon in advance. In Army medical facilities, patients normally receive medical care on the basis of statutory entitlement, which creates a pseudo-contractual relationship, and there is an agreement imposed upon the patients to pay the costs of hospitalization as fixed by administrative or statutory procedures. It is noted, however, that, in Army medical facilities, an Army physician is not authorized to enter into a contract with a patient, as such, that would be binding on the Government.

It is interesting to note that, although entitlement to medical care in Army medical facilities is based on a pseudo-contractual relationship, an action based on the failure of Government employees to adhere to standards of proper medical care must be brought as a tort action, rather than as an action for breach of contract. This rule is not completely logical, but it has a historical basis. In this connection, the following language from Colvin v Smith, (11) is instructive:

"A doctor and his patient are at liberty to contract for a particular result, and if that result be not obtained, the plaintiff has a cause of action for breach of contract... This cause of action is entirely separate from malpractice, even though they both ... may arise out of the same transaction. The two causes of action are dissimilar as to theory, proof and damages recoverable. Malpractice is predicated upon the failure to exercise requisite medical skill and is tortious in nature. The action in contract is based upon a failure to perform a special agreement. Negligence, the basis of one, is foreign to the other: The damages recoverable in malpractice are for personal injuries, including the pain and suffering which naturally flow from the tortious act. In the contract action, they are restricted to payments made and to the expenditures for nurses and medicines or other damages that flow from the breach thereof."

Other important factors arising from the distinction between tort and contract actions are that statutes of limitations generally provide a longer period for the commencement of contract actions, (12) and the amount of damages recoverable in a tort action will normally be greater than that recoverable for a breach of contract based upon the same type of physical injury. (13)

## NOTES

1. Malpractice is the equivalent of rendering medical care in a negligent or careless fashion (See Chapter IV). Although use of the word is frowned upon by many medical people who prefer the euphemism "medical negligence", the word will be used herein because it has received general acceptance in the courts.
2. Assault and battery, false imprisonment, libel and slander are more fully described below.
3. See Chapter III. *In Lane v United States, 225 F.Supp. 850 (1964) it has been held recently, however, that in a case where a physician has already operated on the wrong knee, such a "technical assault" did not bar a claim under the Federal Tort Claims Act.*
4. Although there are cases which support this view, e.g., Allman v Hanley, 302 F. 2d 559 (1962), other cases such as Barr v Matteo, 360 U.S. 564, 79 S.Ct. 1335 (1959), appear to support a contrary view. This writer subscribes to the latter view, but is presenting material in this book on the assumption that the weight of opinion may be proven to be correct. Although this may appear to be a cowardly procedure, it carries a by-product that will assist in individual medical personnel to render better medical care. In any event, under U.S.C. 2676, a judgment against the Government in an action under the Federal Tort Claims Act constitutes a bar by the claimant against the officer or employee whose act or omission gave rise to the claim. This is protection to the officer and employee. *State*
5. Chapter III.
6. Special problems may arise in oversea areas by reason of the provisions of international agreements and local foreign laws, a subject too vast for discussion in this handbook.
7. Lane v Calvert, 215 Md.457, 138 A. 2d 902 (1958).
8. Norton v Argonaut Insurance Company, 144 So. 2d 249 (1963).
9. Parker v Port Huron Hospital, 361 Mich.1, 105 N.W. 2d 1 (1960).
10. A tort may be a civil wrong as well as a crime. For example, an assault, which is a tort for which civil damages may be obtained, may also be the basis for a criminal prosecution. In this handbook, however, we will treat wrongful acts in their civil connotation.
11. 276 App. Div.9, 92 N.Y.S. 2d 794 (1949).
12. Noel v Proud, 367 P. 2d 61 (1961).
13. Barbire v Wry, 183 A. 2d 142 (1962); Zostawtas v St Anthony Padua Hospital, 178 N.E. 2d 303 (1961).

## Chapter II

### THE ARMY MEDICAL SERVICE

1. Introduction. In the area of the federal Government's liability for damages resulting from malpractice, the Army Medical Service does not stand in a position substantially different from that of the other medical services of the federal government. In view of the fact that this handbook is directed to government liability for acts of the Army Medical Service, however, it will be helpful briefly to discuss the mission and composition of the Army Medical Service, and its relationship to the patients to whom it renders medical care in Army Medical facilities.
2. Mission of the Army Medical Service. The Army Medical Service has the responsibility for performing all medical services necessary to maintain the health of the Army so that it will be effective in combat. This continuing mission is performed in peacetime as well as during war. (1) In addition, or as part of this mission, the Army Medical Service, under various statutes, (2) regulations (3) and international agreements, (4) has responsibilities for rendering care to persons who are not members of the Army, such as members of the other Armed Services, dependents of military personnel, members of the forces of signatories to the NATO Status of Forces Agreement, and others.
3. Composition of the Army Medical Service, generally. The Army Medical Service is headed by The Surgeon General, who has overall responsibility. He is a staff officer in Headquarters, Department of the Army. In addition, he commands specified Army medical installations, such as General Hospitals, which are known as Class II Activities of the Department of the Army. He is assisted by various staff officers.

The Army Medical Service consists of the Medical Corps, the Dental Corps, the Veterinary Corps, the Medical Service Corps, the Army Nurse Corps, the Army Medical Specialist Corps, contract surgeons, professional consultants, warrant officers, enlisted personnel and civilian employees.

These include persons whose skills run the gamut of medicine, dentistry, related medical sciences, <sup>and</sup> abilities required to furnish administrative support. They are physicians, dentists, veterinarians, nurses, administrators, technicians and such other persons as may be necessary effectively to render complete medical and dental care, including preventive medicine (5) and dentistry, and the furtherance of medical research and development. (6)

Whether they are military or civilians, personnel of the Army Medical Service are subject to the rules of law which govern personal and governmental liability for damages for the death or injury of patients in Army medical facilities.

4. Army Medical Treatment Facilities. Dispensaries and hospitals are the types of medical treatment facilities most commonly maintained to render patient care in the Army. These may be of various sizes, with varying missions. Their sizes and the make-up and composition of their staffs depend upon their missions, including the size and type of patient population to be served, and the availability of personnel, supplies and equipment.

Most Army medical treatment facilities are commanded by physicians who are commissioned officers in the Medical Corps, but, on occasion, they may be under the command or supervision of contract surgeons or civilian physicians. Within the guidelines established by statutes and regulations, the person in command or in<sup>2</sup>charge of each facility is responsible for determining which persons are authorized care in his facility, and when they should be discharged, or transferred to another facility. (7) He is also responsible for supervising

patient care and treatment, and for the administrative management of the facility and its assigned personnel.

Except when he is the only medical person present at an Army medical facility, the commander or other person in charge normally assigns the performance of many of his responsibilities to others on his staff. In performing their assigned functions, staff members are required to follow recognized professional procedures as well as administrative and statutory regulations and restrictions, as applicable.

As a general rule, State and local laws are not binding upon Army medical treatment facilities. (8) As a matter of policy, however, there may be occasions when a particular State or local law should be complied with, even though there may be no legal obligation to do so, and this is provided for in Army Regulations.

The preceding paragraph does not, however, relieve the staff of the facility from abiding by those precepts of patient care which are accepted as proper according to standards of the medical or dental profession in the local community. As will be noted, liability of the Government or individual persons for damages for medical torts depends upon whether there has been compliance with local professional standards or laws, as applicable (9).

##### 5. The Physician-Patient Relationship in Army Medical Treatment Facilities.

A person's entitlement to medical care in Army medical treatment facilities depends upon the provisions of applicable federal statutes and Army Regulations (10). It may vary from absolute entitlement, as in the case of military personnel on active duty, to entitlement on a "space-available" basis, as in cases of retired personnel and military dependents.

When a person entitled to medical care is admitted to any Army medical facility, there normally is no assurance that the patient will be treated by a physician of his choice. In fact, a patient in Army medical treatment facilities normally is not even assured of continued attention by the physician who commenced his care or treatment.

Under these circumstances, the classical physician-patient relationship that may exist in private medical practice does not normally exist between a patient and an individual Army physician in the course of care in an Army medical treatment facility. This may have some bearing on the question of the validity of suits brought against individual physicians <sup>of the Army Medical Service</sup> for malpractice.

## NOTES

1. Paragraph 38, Army Regulations 10-5; paragraph 4, Army Regulations 40-1.
2. 10 United States Code 1071-1085.
3. Army Regulations 40-3, generally; Army Regulations 40-121.
4. For example, the NATO Status of Forces Agreement.
5. See "Some Legal Aspects of Military Preventive Medicine", Appendix A.
6. Army Regulations 40-1 contain a general description of duties.
7. In connection with the disposition of patients, see "Army Medical Boards", Appendix B.
8. This freedom is based upon the legal proposition that a valid federal function enjoys constitutional immunity from State or local non-federal regulation.
9. See, for example, Chapters III and IV. In foreign countries, it may be necessary to comply with local legal requirements.
10. See, particularly, Army Regulations 40-3 and 40-121.

### Chapter III

#### THE FEDERAL TORT CLAIMS ACT

1. Purpose. The Federal Tort Claims Act (1) represents an almost complete rejection by the federal government of the doctrine of sovereign immunity (2) in the area of negligent torts. With certain specified exceptions, (3) the Act is designed to permit claims and suits against the government for damages for malpractice, as well as other negligent acts or omissions of its employees, just as a claim or suit <sup>may</sup> could be brought against a private individual under like circumstances.
2. Provisions of the Act, generally. The Federal Tort Claims Act is contained in a series of sections now found in ~~title~~ 28, United States Code. (4) It provides for the administrative settlement and judicial determination of claims against the Government based on the alleged malpractice or other negligence of its employees. The administrative settlement of claims against the Government contemplates their adjudication by methods that do not involve suits in court. For example, under the Federal Tort Claims Act, if a claim is for an amount under \$2500, a claimant need not sue the Government in court in order to collect damages (5). In this instance, the Government may have the claim reviewed by qualified Government personnel, and, if they determine the claim to be valid, arrangements will be made to pay the claim. If the claim is administratively rejected, the claimant may sue on the claim in court. If, however, a claim under the Federal Tort Claims Act is for a sum in excess of \$2500, the claimant is required to institute a suit for damages against the Government in a Federal District Court, in order to have the claim adjudicated. (6) Cases tried in Federal Court are heard by a judge, sitting without a jury (7).

Under the Act, the United States may be liable for money damages for personal injury or death caused by the negligent or wrongful act or omission of any officer or employee of the Army acting within the scope of his office or employment, under circumstances where the United States, if a private person, would be liable to the claimant in accordance with the law of the place where the act or omission occurred. (8) Except in special circumstances, claims allowable under the act must relate to acts which occurred in the United States and the areas covered by the United State District Court for the District of the Canal Zone and the District of the Virgin Islands. The Act does not cover claims arising in foreign countries. (9) In the case of a member of the military or naval forces of the United States, "acting within the scope of his office or employment" means acting in line of duty (10).

There are several substantive exceptions under the Federal Tort Claims Act, but, of these, the most important provide that the Act does not apply to

a. Any claim based upon an act or omission of an employee of the government, exercising due care, in the execution of a statute or regulation, whether or not the statute or regulation is valid, or based upon the exercise or performance of the failure to exercise or perform a discretionary function or duty on the part of a federal agency or an employee of the Government, whether or not the discretion is abused (11).

b. Any claim arising out of assault, battery, false imprisonment, false arrest, malicious prosecution, abuse of process, libel, slander, deceit, misrepresentation or interference with contract rights. (12)

3. Negligent or Wrongful Acts or Omissions. The language of The Federal Tort Claims Act appears to lay down a simple basis for applying the law of negligence in any particular case. Thus, the applicable law is the law of the place where

the act or omission occurred. The Act does not contemplate liability without fault on the part of the government, (13) except to the extent that the law of the place where the act or omission occurred would make a private person absolutely liable. (14) The Act adopts the general doctrine of respondeat superior (15).

Thus, the Act would authorize a claim for damages for malpractice based upon the alleged negligent act or omission of an officer or employee of the Army Medical Service in rendering medical or dental care under authorized circumstances to a patient who is authorized to receive the care according to statutes and regulation, and <sup>is</sup> not otherwise barred from making a claim (16).

4. Persons Who May Claim. The Federal Tort Claims Act opened the door to claims by most persons for damages arising from the alleged malpractice of officers or employees of the Army. The following are, however, barred from claiming under the Act:

a. Military personnel may not claim damages arising from alleged malpractice which occurred while on active duty. (17)

b. A civilian employee who is a beneficiary under the Federal Employee's Compensation Act (18) or the Longshoreman's and Harbor Worker's Compensation Act (19) may not claim damages arising from alleged malpractice while he was receiving medical care in an Army medical facility as a beneficiary under the Compensation Acts.

c. The Federal Civil Defense Act (20) provides that, in the event of a national disaster, the federal government will not be liable for death or personal injury caused by the negligence of a federal officer or employee in the performance of his duty while carrying out the provisions of the Act.

It should be noted, however, that dependents of barred military and civilian personnel may claim damages under the Federal Tort Claims Act arising from alleged malpractice in Army medical facilities, and the serviceman or employee may join, claiming subsequent medical expenses or other appropriate damages. (21) It also appears that a federal prisoner, if negligently treated in an Army medical facility, could claim damages. (22)

5. Statute of Limitations. A suit based on malpractice must be asserted against the United States under the Federal Tort Claims Act within two years after the right of action first accrues. (23) There are differences of opinion in various federal courts on the question whether federal or local state law should be used to determine the date when the claim accrues. (24) The United States Circuit Court of Appeals for the Fifth Circuit has held, in Quinton v United States (25) that federal law fixes the date upon which the period of limitations under the Federal Tort Claims Act commences to run in malpractice cases, and that, under federal law, a malpractice suit can be maintained within two years after the plaintiff discovers, or, in the exercise of reasonable diligence should have discovered, the existence of the acts of malpractice upon which his claim is based.

The facts of the Quinton case, as stated by the court, are as follows: In 1956, the plaintiff was serving in the United States Air Force, and was stationed at Larson Air Force Base, in the State of Washington. On May 17, 1956, while his wife was under base hospital care, she was given three transfusions of RH positive blood, although her correct blood type was RH negative. It appeared that plaintiff and his wife did not learn of, and, in the exercise of reasonable care could not have learned of this error until June 1959, during the wife's pregnancy. The complaint, which was filed on August 29, 1960,

alleged that, as a "direct result of the transfusions of incompatible blood", plaintiff's wife gave birth to a stillborn child on December 17, 1959, and that she cannot safely bear other children without, in all probability, their being stillborn, blind or mentally defective. The Circuit Court of Appeals reversed an order of the District Court which had dismissed the complaint on the ground that it had been filed more than two years after the claim had accrued under the law of the State of Washington.

## NOTES

1. 28 U.S.C. 1346(b), 1402, 2401, 2402, 2671-2674, 2679, 2680.
2. See, *Cohens v Commonwealth of Virginia*, 6 Wheat 274, 5 L.Ed 257 (1821), *Kavananaka v Polyblank*, 205 U.S. 349 (1907), *Dalehite v United States*, 346 U.S. 15, 73 S. Ct. 956 (1953). Other statutes waiving sovereign immunity may be found at 10 Stat. 612, 12 Stat. 765, 24 Stat. 505, 36 Stat. 851, 5 U.S.C. 751, 41 Stat. 526, 43 Stat. 1112, 49 Stat. 1049, 23 Stat. 350, 40 Stat. 880, 41 Stat. 1436, 57 Stat. 372, 59 Stat. 225, 37 Stat. 586, 42 Stat. 1066, 57 Stat. 66.
3. 28 U.S.C. 2680.
4. See footnote 1.
5. 28 U.S.C. 2672.
6. 28 U.S.C. 1346, 1402(b).
7. 28 U.S.C. 2402. When a suit against the United States under the Federal Tort Claims Act is joined with a suit against a joint tortfeasor which is to be tried by a jury, the jury may render a verdict in one suit and the judge can make his own decision in the suit involving the United States. *Eastern Air Lines v Union Trust Company*, 221 F. 2d 62 (1955). Of course, the judge may also consider the jury verdict as advisory, and adopt it in the suit against the United States.
8. 28 U.S.C. 1346, 2672, 2674. *Massachusetts Bonding & Insurance Co. v United States*, 352 U.S. 130, 77 S.Ct. 187 (1957), *Hatahley v United States*, 351 U.S. 173, 76 S.Ct. 745 (1956). The government may not be held liable for interest prior to judgment, or for punitive damages. If, however, in any case where death ensued, the law of the place where the act or omission complained of occurred provides, or has been construed to provide, for damages only punitive in nature, the United States shall be liable for actual or compensatory damages, measured by the pecuniary injuries resulting from the death of the persons as to whom the action was brought. 28 U.S.C. 2674.
9. 28 U.S.C. 1346, 2680(k).
10. 28 U.S.C. 2671.
11. 28 U.S.C. 2680(a).
12. 28 U.S.C. 2680(h). In *Costley v United States*, 181 F.2d 723 (1950), suit was brought for negligent treatment of a dependent wife in an Army hospital. The government claimed that her admission to the hospital was discretionary and that, therefore, the government could not be held for negligent injury. The court stated that although admission to the hospital was discretionary, once the dependent had been admitted, there was a duty to treat her, and negligence in performing this duty would sustain a claim for damages.
13. *Dalehite v United States*, cited at footnote 2.

14. *United States v Praylou*, 200 F. 2d 291 (1953), cert. den. 347 U.S. 934 (1954). Early decisions under the Act indicated that the Government could not be held liable for negligent acts of employees while performing governmental functions that had no parallel in the activities of private persons. *Feres v United States*, 340 U.S. 135, 71 S.Ct. 153 (1950) with which compare, *Brooks v United States*, 337 U.S. 49, 69 S.Ct. 910 (1949). See, also, *Dalehite v United States*, cited at footnote 2. Later decisions of the Supreme Court have departed from this theory, and the *Feres* and *Dalehite* cases should be accepted as having been based on peculiar factual situations and policy. See, *Indian Towing Company v United States*, 350 U.S. 61, 76 S.Ct. 122 (1955), *Rayonier, Inc. v United States*, 352 U.S. 315, 77 S.Ct. 374 (1957), *United States v Muniz*, 374 U.S. 150, 83 S.Ct. 1850 (1963).

15. An employer is responsible for the acts of his employee when performed within the scope of his employment. Regarding the term "line of duty" as used in the Act, see *Myers v United States*, 219 F. Supp. 71 (1963), *Williams v United States*, 350 U.S. 857, 76 S.Ct. 100 (1955), *Mandelbaum v United States*, 251 F. 2d 748 (1958).

16. *Feres v United States*, cited at footnote 14.

17. *Feres v United States*, cited at footnote 14. The doctrine of this case has been applied to cases involving retired military being treated in federal hospitals. *Pettis v United States*, 108 F. Supp. 500 (1952), *O'Neill v United States*, 202 F. 2d 366 (1953). But, compare *Brooks v United States*, cited at footnote 14, where a serviceman was killed while on leave, and *United States v Brown*, 348 U.S. 110, 75 S.Ct. 141, (1954), *Crim v United States*, 209 F. Supp. 353 (1962), *Friedland v United States*, 209 F. Supp. 684 (1962), *Fair v United States*, 234 F. 2d 288 (1956) which involved medical care of veterans who were not "retired" persons.

18. 5 U.S.C. 751, et seq. *Johansen v United States*, 343 U.S. 427, 72 S.Ct. 849 (1952). See, also, *U.S. v Yellow Cab Co.*, 340 U.S. 543, 71 S.Ct. 399 (1951), *Drake v Treadwell Construction Co.*, 299 F. 2d 789 (1962), *United States v Weyerhaeuser S.S. Co.*, 294 F. 2d 179 (1961).

19. 5 U.S.C. 150 k-1.

20. 50 U.S.C. Appendix 2294.

21. *Grigalauskas v United States*, 103 F. Supp. 543 (1951), *Costley v United States*, cited at footnote 12, *Willsam v United States*, 76 F. Supp. 581 (1948), *Herring v United States*, 98 F. Supp. 69 (1951), *Messer v United States*, 95 F. Supp. 512 (1951), *United States v Gray*, 199 F. 2d 239 (1952).

22. *United States v Muniz*, cited at footnote 14.

23. 28 U.S.C. 2401 (b)

24. There is a discussion of various rules in *Quinton v United States*, 304 F. 2d 234 (1962).

25. Case cited at footnote 24. Followed in *Hungerford v United States*, 307 F. 2d 99 (1922).

## Chapter IV

### MALPRACTICE - GENERALLY

1. Introduction. This chapter discusses the law of malpractice from the standpoint of the liability of the federal government for damages under the Federal Tort Claims Act. The standards of care which are applicable in considering the liability of the government for the acts of its officers and employees are, however, also applicable to questions of liability of the officers and employers as individuals. For example, in Stivers v George Washington University (1) the court held that where both a hospital and a staff physician were sued for damages for alleged malpractice, verdicts in favor of the physician and against the hospital were inconsistent and incompatible on their face, because the hospital could not be liable if the physician, who was its servant, was not liable.

It is usually understood that a claim for malpractice can only arise when there is a physician-patient relationship between the injured patient and the physician. In civilian medical practice, the usual physician-patient relationship commences when a patient voluntarily goes to a physician, and the physician accepts the patient. In civilian life, a physician is not obligated to accept all patients.

In the Army, the situation is somewhat different. Patients who are treated in Army medical facilities are treated because they are entitled to treatment by law or regulation. And Army medical personnel are required to treat all patients entitled to care who are admitted for treatment. It is true that, on some occasions, an Army physician may exercise a choice whether to treat a patient entitled to medical care in an Army facility,

or a patient may insist on treatment by a physician other than the one designated by the facility commander. These occasions are rare, however, so it can be seen that the relationship between physician and patient in the Army medical service is not, theoretically, a voluntary, free association.

There is another important difference between the civilian and Army physician-patient relationship.

In civilian life, when a patient is accepted by a physician, the physician has personal responsibilities to the patient which he cannot *cancel unilaterally* neglect. For example, if the physician desires to go on a vacation, he must furnish a substitute satisfactory to the patient. Moreover, if he terminates his relationship with the patient, without the patient's consent or fault, before the patient is cured, he may be charged with abandonment.

In the Army medical service, patients basically are patients of the medical facility concerned. Thus, although treatment of an Army patient may be started by a particular Army physician, the patient has no legal right to continued treatment by that physician if the physician or the facility commander decides that a substitute physician should be furnished (2). The patient's alternative, if he does not desire treatment by the successor physician, is to seek treatment elsewhere, unless the patient is a military person who is required to accept treatment by the substituted physician.

The fact that an Army patient may not have the right to continued services of a military physician does not excuse that physician if he fails to treat a patient assigned to him without an adequate excuse or without furnishing a substitute. This would raise the same legal problems that would arise if a patient in civilian life were abandoned by his civilian physician.

A suit under the Federal Tort Claims Act for damages arising out of malpractice is one that is based upon the alleged negligent act or omission of an officer or employee of the Army in rendering medical or dental care under authorized circumstances to a patient who is authorized to receive the care according to statutes and regulations. The standards of professional care applied are those which are in effect in the state in which the alleged act or omission occurred. (3)

The rules of negligence generally applied in negligence actions are also applied in suits based upon malpractice (4). In malpractice actions, however, the basic rules of negligence are usually applied with some modifications, because the courts recognize that medicine is a highly technical field having many aspects separate and apart from the common run of negligence actions (5).

In the ordinary action for damages based on negligence by a layman, negligence has been defined as "the doing of something which an ordinarily prudent person would not have done under the same or similar circumstances, or the failure to do something which an ordinarily prudent person would have done under the same or similar circumstances." (6) But, in view of the fact that a claim of medical malpractice raises questions concerning the standards of a member of a highly skilled profession, the courts do not look to the standards of care required to be observed by "the ordinarily prudent person" in such a case. Instead, the standards of care are those which are related to the conduct of physicians, or other practitioners of the healing arts, as applicable. (7)

This is illustrated in Klimkiewicz v Karnick. (8) This was an appeal in an action for malpractice against a physician, where the lower court had given instructions to the jury in which the standard of care required of a physician was described as the degree of care which a person of ordinary

intelligence and prudence or an ordinarily prudent person would have exercised under the same or similar circumstances to prevent injury to himself or to another. In holding these instructions to have been incorrect, the Supreme Court of Colorado said: "In this case the plaintiff is not proceeding against a 'person of ordinary intelligence or prudence', 'an ordinarily prudent person'. Rather, she is proceeding against a person in whom she had confidence as being one having special knowledge and skill in his field of endeavor."

In Jines v General Electric Company, (9) the court, discussing the application of ordinary rules of negligence to standards of medical practice said: "The prudent man standard requires some elucidation here, for the prudent layman is not qualified to interpret X-rays or take other professional steps necessary to a diagnosis of the condition of tuberculosis ... Thus ... it is incumbent upon the plaintiff ~~in~~ this class of cases to establish the standard of care not of the ordinary prudent man, but of the prudent, skilled, trained physician".

2. Standards of Care. When the Army renders medical care, it implies that its medical personnel possess that reasonable degree of learning or skill that is ordinarily possessed by similar types of personnel in the locality or community in which the care is being given. The Army medical personnel are under a duty to use reasonable care and diligence in the exercise of their respective skills and in the application of their learning to accomplish the care undertaken. They are under a further obligation to use their best judgment in exercising their skills and applying their knowledge. (10) The government may be liable for damages, under the Federal Tort Claims Act, for injury to or death of a patient, if, in the case in issue, Army medical personnel lacked the knowledge or skill required, or failed to use reasonable care in applying their knowledge or skill, or failed to use their best judgment (11).

The rule relating to the learning and skill of a physician (or other medical personnel) does not require him to possess that extraordinary learning and skill which belong to only a few men of rare endowments, ~~but it does require him to him to possess that extraordinary learning and skill which belong to only a few men of rare endowments~~, but it does require him to have that degree of learning and skill that is possessed by the ordinary member of his profession in good standing (12). He is bound to keep abreast of the times, and departure from approved methods in general use, if it injures the patient, will render the government liable, however good his intentions might have been. The local community standard of practice is the criterion (13).

The rule relating to reasonable care and diligence does not require a physician to exercise the highest possible degree of care. (14) To render the Government liable, it is not enough to show that he exercised a lesser degree of care than some other physician might have shown -- there must have been a want of ordinary and reasonable care, which led to a bad result. The fact that a physician is employed by the Government does not necessarily mean that he has a higher duty of care than is required of the private practitioner. (15) Most courts do, however, hold a specialist to higher standards. (16)

The rule requiring a physician to use his best judgment does not render the government liable for a mere error of judgment on his part, (17) provided he has the required knowledge and skill, and does what he thinks is best after a careful examination. In any case raising the question of the judgment of a medical practitioner, much latitude is granted in his favor. Thus, the courts have said:

a. "The law recognizes, and we think properly so, that the surgeon's hand with its skill and training is, after all, a human hand, guided by a human brain in a procedure in which the margin between safety and danger sometimes measures little more than the thickness of a piece of paper." (18)

b. "Because of the wide difference which must be allowed for differences of 'judgment' in a learned profession, testimony of other physicians that they would have done something different, standing alone, is insufficient to sustain a verdict for the plaintiff." (19)

c. A physician "must have latitude for play of reasonable judgment, and this includes room for not too obvious or gross errors according to the prevailing practice of his craft." (20)

Even though an incorrect diagnosis may be excused, (21) a physician should not attempt a case which is beyond his capability, but should refer it to a better qualified person. (22) A patient has the right to assume that his physician will advise him properly in all matters pertaining to his ailments, and this includes advice as to who are properly qualified to assist in his treatment. (23)

From the standpoint of individual liability, a physician may also be held liable for damages because of the negligent acts of others in connection with his patient. For example, he may be held liable for the negligence of his nurse, or of his laboratory assistant, or, under some circumstances, for the negligence of a substitute physician. (24) On the other hand, a surgeon normally is not responsible for the negligence of an anesthetist, as the latter is usually an independent agent; (25) also, in connection with the surgical care of a patient, the surgeon usually is not liable for negligent

preoperative (26) or post operative (27) care rendered by employees of the hospital.

3. The Locality Rule. In order to establish standards that are applicable in a malpractice action, a practitioner's acts or omissions are usually measured against those standards which are ordinarily followed by other similar practitioners practicing in the same locality or community. (28) As the court said in Bickford v Lawson, (29): "The question as to whether the reduction and treatment of a fractured limb without the use of an X-ray machine constitutes negligence depends on what an ordinarily skilled physician practicing in that vicinity, in the exercise of due care and professional judgment, would be required to do under like circumstances."

In applying the "locality" rule, question is often raised as to the area covered by the local community, and there is a tendency in the courts to apply standards found in geographical areas larger than those implied in the words "locality" or "community". (30)

The "locality", "community" or local community" rule grew up in days when, primarily because of lack of communications, different standards of practice existed in different communities. Today, with the existence of mass media of instruction and information, together with the establishment of communications available to all but the most isolated, the locality or community concept is undergoing a change. For example, in some cases, the "locality" could include "similar communities" (31). Thus, in a Florida case, the court took judicial notice that Miami is a community similar to West Palm Beach. (32) And, in California, a court said that "community" does not mean "a village or section of town, but, rather, it means such area as is governed by the same laws, and the people are unified by the same sovereignty and customs." (33)

It should be noted, however, that the government may not avoid liability to a patient on the ground that its personnel followed a custom or procedure of other similar practitioners in the community, when that custom or procedure is shown to be negligent. (34) An example of this is <sup>seen</sup> shown in Favorola v Aetna Casualty and Surety Company, (35) which was an action by a patient against a radiologist for injuries sustained as the result of a fall which occurred during an X-ray examination. The X-ray examination had been ordered as part of a general check-up for a 71-year old woman who had complained to her physician of stomach pains, general fatigue and an episode of fainting or "passing out". In order to have the check-up, the patient had been admitted to a hospital. She went through a series of X-rays, and, while standing during the taking of the G.I. series, she suddenly and unexpectedly fainted, fell to the floor, and was injured. The court said that in view of the patient's history, the radiologist should have taken extra precautions to guard her against a fainting fall. The radiologist stated that he had not known about the patient's tendency to faint, that this part of her history had not been sent to him, and that in his geographical area, it was not necessary for radiologists to check the medical histories of referred patients before taking X-rays. Nevertheless, the court held for the plaintiff, on the basis that failure to have known the patient's medical history prior to taking X-rays was negligence under the circumstances.

On the other hand, where two or more methods of care or treatment are acceptable in a community, the proper use of one of the methods will protect the government against liability even though an unsatisfactory result is achieved. (36)

The case of Kolesar v United States (37) casts an interesting side-light on the "locality" rule as it might affect military medical facilities. This case, involving a claim for malpractice in a naval hospital in Florida, refers to the fact that the Supreme Court of Florida had previously pointed out that the "locality" rule of medical standards had lost much of its significance today with the increasing number and excellence of medical schools, the free interchange of scientific information, and the consequent tendency to harmonize medical standards throughout the country. The court proceeds to bludgeon the "locality" rule as applied to military hospitals by stating: "It (the language of the Supreme Court of Florida) has particular significance in reference to a Federal hospital and a military community, administered on a national basis, wherein naval medical officers from many medical schools, and many States, practice without being subject to local board examinations otherwise required of personnel practicing medicine in the State wherein the hospital is located. Such an institution is a community apart and cannot be said to have contributed nothing to the standards of its geographical location or unto itself."

The language quoted, however, appears to be in conflict with provisions of the Federal Tort Claims Act that state that the government shall be treated as a private person, in accordance with the law of the place of the alleged injury. (38)

4. Proximate Cause. Not every negligent act of omission or commission gives rise to a cause of action for injuries sustained by another. It is only when injury to a person who himself is without contributing fault has resulted directly and in ordinary natural sequence from a negligent act without the intervention of any independent efficient cause, or is such as ordinarily

and naturally should have been regarded as a probable, not a mere possible, result of the negligent act, that the injured person is entitled to recover damages as compensation for his loss. Conversely, when the loss is merely a possible, as distinguished from a natural and probable result of negligence, recovery will not be allowed. (39)

Thus, even though a government physician may be negligent in treating a patient, the patient may not hold the government for damages unless he can show that there was an injury which proximately resulted from the physician's negligence. (40) In McBride v Roy, (41) defendant failed to X-ray plaintiff's broken leg. The plaintiff could not show, however, that defendant's treatment would have been different if he had taken X-rays. In fact, the treatment was proper despite the omission to take X-rays. The court said that although the plaintiff had suffered from the broken leg, and the defendant had been negligent in not taking X-rays, there was no showing that the suffering would have been less if X-rays had been taken.

It has been held that the negligence of a physician need not be established as the proximate cause of an injury with such absolute certainty as to exclude every other conclusion. As the court said in Barham v Widing: (42) "If ... it is necessary to demonstrate conclusively and beyond the possibility of a doubt that the negligence resulted in the injury, it would never be possible to recover in a case of negligence in the practice of a profession which is not an exact science."

In the area of proximate cause, the civilian case of Norton v Argonaut Insurance Company (43) is of interest. In this case, surviving parents brought suit against a doctor, a hospital nurse and the hospital for the wrongful death of their child, who died of an overdose of Lanoxin, a derivative of

digitalis, which was administered to the child by injection while she was a patient in the hospital. Although the drug comes in various forms suitable for administration either orally or by injection, the doctor intended the drug to be administered orally. The amount prescribed for the child was a lethal amount if injected, and the doctor failed to indicate on his physicians's order sheet whether the drug was to be administered orally or by injection. Thereafter, a nurse, who was unfamiliar with the drug either in its various forms for administration, or in its effect by various dosages, administered the drug by injection even though she had had doubts about the correctness of the doctor's order. As a result, the child died. The court found that the doctor did not follow accepted practice when he failed to indicate the method of administration, and it also found that the nurse had been negligent. The doctor claimed that he should not be liable because death would not have occurred if the nurse had not been negligent; he further argued that the negligence of the nurse was so gross, inconceivable and unpredictable that her negligence and not his had been the proximate cause of the death. The court, holding the doctor also liable said:

"The evidence in the case at bar leaves not the slightest doubt that when Dr. Stotler entered the order for the medication on the chart, it was the duty of the hospital nursing staff to administer it. Dr. Stotler frankly concedes this important fact and for that reason acknowledged that he ... was under the obligation of specifying or in some manner ... indicating the route (of administration) ... In dealing with modern drugs, especially of the type with which we are herein concerned, it is the duty of the attending physician who knows that the prescribed medication will be administered by a nurse or third party, to make certain as to the lines of

communication between himself and the party whom he knows will ultimately execute his orders. Any failure in such communication which may prove fatal or injurious to the patient must be charged to the prescribing physician who has full knowledge of the drug and its effects on the human system. The duty of communication between physician and nurse is more important when we consider that the nurse who administers the medication is not held to the same degree of knowledge with respect thereto as the prescribing physician. It, therefore, becomes the duty of the physician to make his intentions clear and unmistakable. If, as the record shows, Dr. Stotler had ... specified the route to be oral, it would have clearly informed all nurses of his intention to administer the medication by mouth. Instead, however, he wrote his order in an uncertain, confusing manner, considering that the drug in question comes in oral and injectible form ..."

In State v Housekeeper, (44) a patient developed meningitis after a mastectomy, and died. In denying recovery to her husband against the surgeon, the court established the rule that if death is caused by a disease not produced by an operation, the surgeon may not be held liable; moreover, even if a disease resulting in death is caused by an operation, the surgeon is not liable if he performed the operation with the patient's consent in a skillful manner and under the belief that the operation was proper.

Meyers v Clarkin, (45) was a malpractice action against a surgeon who diagnosed a case as a fracture of the upper third of the femur, but failed to notice a break of the femur. He failed to give any treatment for the latter fracture and this necessitated additional operations and caused further injuries. The court speculated that the physical consequences to the patient

might have been the same even if the original diagnosis had been correct.

4. Contributory Negligence. In a malpractice action, the government, in appropriate cases, may defend against a claim for damages by proving that the patient was also negligent, and that his negligence contributed to the injury or damage. Contributory negligence may be a defense even when res ipsa loquitur is applicable. (46) Proof of contributory negligence on the part of a patient may bar all recovery, in some jurisdictions. In other jurisdictions where the doctrine of "comparative negligence" is followed, proof of contributory negligence need not bar full recovery, but it could reduce the amount recoverable according to proportionate shares of negligence of the patient and the defendant.

The facts that the patient failed to follow the physician's advice, or failed to return for an examination or treatment may be considered to be contributory negligence on the part of the patient. In Preston v Hubbell, (47) after extraction of a tooth and repair of her jaw, plaintiff failed to follow her dentist's advice to eat a soft diet, take medication, and return for treatment. As a result, her jaw became infected and her system became weakened. Her failure to do her part was considered to be contributory negligence.

There was a different finding in McClees v Cohen (48). This was an action against a dentist based on the fact that he had extracted the wrong teeth. Plaintiff discovered the error after she went home, and her sister took her to another dentist to have the proper teeth extracted. The court rejected the defendant's claim that this was contributory negligence.

An interesting facet is disclosed in Sproul v Russell, (49) another dental case. This was an action to recover money which the plaintiff had paid the defendant to construct a set of false teeth. Plaintiff had alleged that after one set had been made which did not fit, defendant had had a second pair made which also did not fit. Although the defendant had been ready to adjust the second set, the plaintiff had not come to him. The court held that the defendant should have had a reasonable opportunity to adjust the second set, and that the failure of the plaintiff to have permitted this was a bar to her recovery. The court said: "Sometimes a defect in the way a set of teeth fits may be corrected by a little filing away of a place where the plates rub the gums. Sometimes the plates can be built up a little in some places so that they will fit. Any of these things might be done in a few minutes. It would be a harsh rule indeed that would deprive a dentist of pay for his services on account of defects which could be remedied by a few moments work."

The Sproul case indicates that mere dissatisfaction of a patient with a physician's treatment may not, in every case, justify the patient in going to another physician and claiming damages from the first physician for subsequent injury.

On the other hand, the term "uncooperative patient", when used by medical people, does not always mean that a patient was contributorily negligent. Occasionally, this term is used to describe a patient who is "objectionable", or a "nuisance".

5. Specific Problem Areas. A physician is the product of many years of intensive training centered around study and treatment of the human body and its illnesses.

No physician has yet unlocked all the secrets of the human body. The mysteries of medicine continue to present a constant challenge.

Medicine is an art and an inexact science. The individual response of patients to treatment and the fallibilities of patient and physician influence the outcome in any case, and an unforeseen result is a possibility in almost any case involving medical treatment.

Some bad results are inevitable, despite the use of utmost care and skill by the physician. On the other hand, some bad results are avoidable and unnecessary. A bad result may, of course, occur because a patient fails to cooperate with his physician. But, occasionally, a bad result occurs because the physician has been negligent.

It must be conceded that a patient who is injured through negligent treatment by a physician should be able to recover compensatory damages.

As has been indicated, malpractice arises from a <sup>disruption</sup> description of the relationship between a patient and treating medical personnel that is based upon negligence of the latter. Negligence is the legal foundation for malpractice litigation. The real reason why malpractice litigation, is commenced, however, is often found in a faulty personal relationship between the patient and his treating physician that finds the patient angry at the physician for one reason or another. In fact many negligent injuries to patients are overlooked by them when they feel a close rapport with their physicians. In this connection, but in a broader scope, the following words of Lieutenant General Leonard D. Heaton, The Surgeon General of the Army, bear repetition: (50)

"It is practically inevitable that, with the complexities surrounding the practice of medicine today, and the increasing public interest in the subject, some allegations of malpractice will be made. Fortunately, these have not been many and have not involved the Army Medical Service disproportionately. While taking comfort in the above, we should not allow ourselves ever to become complacent.

"A related subject is that of complaints about medical care. These are encountered somewhat more frequently. To view them in their proper perspective, one must bear in mind that the satisfied patient is less inclined to write a letter than the patient who is not satisfied, though we receive also a gratifying number of favorable letters. Every communication pertaining to the quality of medical care in our installations which is received in my office is given thorough consideration, and the great majority are answered personally by me. An informal review of the relevant files by my staff reveals that in only approximately one out of five such instances is there a material basis in fact for the complaint. While this is reassuring, we must not be complacent but accept the challenge and ask ourselves: 'If this is the case, why were the other four written?'

"A review of these files reveals, naturally, that many factors prompt the submission of a complaint. These factors frequently overlap and are not easily susceptible of classification. However, either a simple misunderstanding or a breakdown of communication between the patient, or the patient's family on the one hand, and the medical personnel on the other, is usually present. It is important to realize that the term 'medical personnel' includes not only medical and dental officers but every member of the medical team who has contact with the patient population of our hospitals and clinics. Nurses, corpsmen, and all members of the medical team speak from a position of authority and responsibility which they sometimes may not fully realize.

"The tremendous technical advances in the science of medicine have considerably complicated the practice of the art of medicine. Patients today possess a greater fund of information and a greater curiosity about medical matters than they did even a few years ago. Today they feel entitled to full explanations where their forebears were content with simple statements. In our practice of medicine we must recognize and accept this situation and strive for simplicity, clarity, and consistency in meeting the demands placed upon us.

"We must remember, too, that the patient who is ill, or thinks he is ill, may be disturbed by relatively minor annoyances which to him become exaggerated out of all proportion to the true situation. I am thinking of such matters as the unexplained delay before the patient with an appointment is seen, the failure of a followthrough when an appointment or a planned admission or discharge has been canceled or postponed, or the casual comment that may unintentionally hurt the patient's pride in himself or confidence in another. These are situations which can usually be avoided or corrected by tact and consideration on the part of all members of our medical team in executing their responsibility for the care of the sick. Attention to these matters does not constitute endorsement of a policy that 'the customer is always right'; it is merely applying sympathetic understanding and firmness tempered with kindness."

In the light of the foregoing, it is helpful, as guidance for future action, to consider specific problems that have arisen.

a. Diagnostic Errors. The following matters alleging errors in diagnosis or failure to take appropriate diagnostic procedures have been the subjects of court actions:

Failure to make necessary diagnostic tests in connection with pregnancy, (51) delay in examining a patient in a hospital, (52), failure to X-ray a fractured limb, (53) finger, (54) or jaw, (55) erroneous diagnosis of a venereal disease, (56) failure to note a second fracture, (57) diagnosis of a heart condition as drunkenness, (58) failure to diagnose the dislocation of a shoulder while the patient was hospitalized for other care, (59) treating a completely cracked jaw as a partially cracked jaw, (60) alleged failure to diagnose an infectious disease while a patient was in the hospital, (61) failure to use X-ray to discover a fishbone left in patient's foot, (62) and failure of a physician to reveal to a patient a diagnosis discovered in a pre-employment physical examination. (63)

b. Foreign Substances Left in Patient. In connection with surgery, damages are sometimes claimed on the ground that a foreign substance was left in the patient. This type of incident has involved a towel left in the abdomen after an appendectomy, (64) part <sup>of a</sup> broken suture needle left in a patient after childbirth, (65) a gauze pad left in patient's body, (66) a cloth sack left in the bowel, (67) gauze left in a wound, (68) gauze left in the mouth after a tonsillectomy, causing throat ulcers, (69) and forceps left in the abdomen. (70)

c. Blood Transfusion Mishaps. Appendix D contains material relating to transfusions with incompatible blood. Other types of problems have arisen in cases where hepatitis followed a blood transfusion, (71) and the needle slipped in the course of a transfusion. (72)

d. Drugs. The administration of drugs has raised problems related not only to the actual method of their administration but also <sup>to</sup> the propriety of their administration. These problems are illustrated in cases where:

An Osteopath negligently injected a hypodermic needle into a patient's back, causing her lung to collapse, (73) a physician, not licensed to prescribe narcotics, gave a barbiturate to a truck driver who was killed when he fell asleep while driving a truck, (74) a drug, alleged to cause breast cancer, was given to a woman who had a family history of breast cancer, (75) a radiologist injected a drug into a patient before skin-testing her for allergies, (76) penicillin was given in error to a patient with a history of allergy to penicillin, (77) a nurse gave an improper drug dosage to a patient because the physician's written instructions were unclear, (78) a physician spilled acid in a patient's eye while removing a cyst, (79) alleged injury to the nerve of an infant as the result of the injection of an antibiotic, (80) improperly prepared novocaine was injected into a patient's thumb, (81) hepatitis was transmitted during injections with unsterile instruments, (82) and drugs were prescribed by unlicensed resident trainees in a hospital. (83)

e. X-ray Injuries. In connection with the use of X-rays, a dental nurse, while X-raying a dental patient, caused electrification, shock and burns (84) a skin condition developed from the excessive use of X-ray, (85) death resulted from X-ray burns, (86) and a patient blacked out and was injured while being X-rayed, (87).

f. Anesthesia Mishaps. The use of anesthesia requires the use of proper care even when local anesthetics are used. Thus, there have been allegations of negligence: When a dentist administered a contraindicated anesthetic to a patient with high blood pressure, (88), and when a patient swallowed two false teeth which were dislodged while the anesthetist inserted an oxygen tube during an operation (89).

g. Failure to Sterilize Instruments. Claims based on the failure to sterilize instruments have arisen based on alleged failure to sterilize surgical instruments before an operation, (90) and the use of an unsterile hypodermic needle in administering an anesthetic. (91)

h. Miscellaneous. In addition to the categories previously listed, there are types of cases which are not easily categorized:

Leg nerves were injured when a defective tourniquet was applied during an operation, (92) a fracture was negligently set, (93), a patient, who had been given an enema was left unattended, became nauseated and dizzy, and fell off a toilet bowl, fracturing his skull, (94) a physician practiced in a field in which he was not qualified, (95) sideboards should have been placed on patient's bed, (96) a fracture was negligently treated, (97) hospital attendants failed to prevent psychotic patients from leaving hospital grounds with resultant death and suicide of the patients, (98) an epileptic hospital patient was permitted to wander into a heating tunnel which had been negligently left open, and died of heat prostration, (99) physicians failed to apply timely cardiac resuscitation after a cardiac arrest during surgery, (100) part of a patient's tongue was cut off while his adenoids were being removed, (101) a urethra was perforated during an operation where it was necessary to use care not to do so, (102) a physician beat a patient

while giving psychiatric treatment, (103) a wound became infected after the removal of a tooth, (104) a dentist cut the patient's mouth while grinding a tooth, (105) a dentist dislodged a patient's tooth which fell down the patient's lung and lodged in his lung, (106) a patient's teeth were injured while she was undergoing abdominal surgery, (107) a physician promised hairline scars, but disfiguring scars developed, (108) a patient required an operation for a prolapsed uterus after childbirth, (109) a dentist removed an abscessed tooth before infection and swelling had been reduced, (110) a physician neglected a patient by failing to continue treatment ~~of while~~ <sup>he</sup> ~~patient who~~ had a leg in a cast, (111) a patient, while walking in hospital, suffered a grand mal seizure and was injured, (112) a hospital failed to continue treating <sup>a</sup> patient for ingested poison, as a result of which the patient died, (113) a hospital refused to admit a child who had been referred by her family physician, (114) electroshock therapy caused a compressed fracture of the ninth vertebra, (115) a patient suffered paralysis of the right arm after abdominal surgery, (116) and a patient suffered urinary incontinence following a prostatectomy. (117)

## NOTES

1. 320 F. 2d 751 (1963)
2. This may raise a question if the physician has peculiar qualifications and he is in the midst of a course of treatment that would, according to accepted medical standards, require him to continue. Often it is necessary to substitute physicians in the Army Medical Service because the original physician has received orders for a change of station.
3. 28 U.S.C. 2674. See, also, Chapter III.
4. Roberts v Parker, 121 Cal. App 264, 8 P. 2d 908 (1932).
5. Sanzari v Rosenfeld, 34 N.J. 128, 167 A. 2d 625 (1961).
6. Edmunds v Ripley, 172 Neb. 797, 112 N.W. 2d 385 (1961).
7. Barbire v Wry, 75 N.J.S. 327, 183 A. 2d 142 (1962).
8. 372 P. 2d 736 (1962).
9. 303 F. 2d 76 (1962).
10. Pike v Honsinger, 155 N.Y. 201, 49 N.E. 760 (1898).
11. In civilian life, the fact that a physician may render gratuitous services does not permit him to avoid his duty to exercise reasonable and ordinary care, skill and diligence in treating his patient. Dubois v Decker, 130 N.Y. 325, 29 N.E. 313 (1891). This rule is also applicable, where negligence, while being a "Good Samaritan", is actionable.
12. Lane v Calvert, 215 Md. 457, 138 A. 2d 902 (1958); Goodlett v Williamston, 179 Okla. 238, 65 P. 2d 472 (1937).
13. Jines v General Electric Co., cited at footnote 9.
14. Leavell v Alton Ochsner Medical Foundation, 201 F. Supp. 805 (1962).
15. Howe v State, 33 Misc. 2d 147, 226 N.Y.S. 2d 933 (1962).
16. Clark v Wichman, 72 N.J.S. 486, 179 A. 2d 38 (1962).
17. Goodlett v Williamston, cited at footnote 12.
18. Hunt v Bradshaw, 242 N.C. 517, 88 S.E. 2d 762 (1955).
19. Jines v General Electric Co., cited at footnote 9.
20. Christie v Callahan, 124 F. 2d 825 (1941).

21. When there has been a mistaken diagnosis, the plaintiff must prove that it ~~is~~ resulted from the failure of the doctor to have exercised ordinary care, diligence and skill in making the diagnosis. Mere proof of a wrong diagnosis is not enough.
22. Tvedt v Haugen, 294 N.W. 183 (1940).
23. Batty v Arizona State Dental Board, 57 Ariz, 239, 112 P. 2d 870 (1941).
24. Stohlman v Davis, 117 Neb. 178, 220 N.W. 247 (1928).
25. Dohr v Smith, 104 So. 2d 29 (1958).
26. Clary v Christianson, 83 N.E. 2d 644 (1948).
27. Shull v Schwartz, 73 A. 2d 402 (1950).
28. Mastro v Kennedy, 57 Cal App. 2d 499, 134 P. 2d 865 (1943).
29. 27 Cal. App. 2d 416, 81 P. 2d 216 (1938).
30. Kolesar v United States, 196 F. Supp. 517 (1961); Couch v Hutchinson, 135 So. 2d 18 (1961).
31. Skeffing<sup>er</sup> v Bradley, 366 Mich. 552, 115 N.W. 2d 303 (1962).
32. Cook v Lichtblau, 144 So. 2d 312 (1962).
33. Gist v French, 136 Cal. App. 247, 288 P. 2d 1003 (1955).
34. See, in this connection, Schmitt v Northern Improvement Company, 115 N.W. 2d 713 (1962), according to which "what usually is done may be evidence of what ought to be done, but what ought to be done is fixed by a standard of reasonable prudence, whether it is complied with or not.
35. 114 So. 2d 544 (1962). See, also, Hillcrest Medical Center v Wier, 373 P. 2d 45 (1962).
36. Roberts v Wood, 206 F. Supp. 579 (1962); Di Filippo v Preston, 173 A. 2d 333 (1961); McBride v Roy, 177 Okla. 233, 58 P. 2d 886 (1936).
37. Cited at footnote 30.
38. Chapter III.
39. Cone v Inter County Telephone and Telegraph Company, 40 So. 2d 148, (1949).
40. Modrzynski v Lust<sup>z</sup>, 88 N.E. 2d 76 (1949).

41. Cited at footnote 36.
42. 210 Cal. 206, 291 P. 173 (1930).
43. 144 So. 2d 249 (1962).
44. 70 Md.162, 16 A. 382 (1889).
45. 33 Ohio App. 165, 168 N.E. 771 (1929).
46. Ybarra v Spangard, 25 Cal. 2d 486, 154 P. 2d 687 (1945). For a discussion of res ipsa loquitur, see Chapter V.
47. 87 Cal.App. 2d 53, 196 P. 2d 113 (1948).
48. 158 Md.60, 148 A. 124 (1930).
49. 135 Kan.620, 11 P. 2d 978 (1932).
50. Department of the Army Technical Bulletin 8-13. "The Surgeon General", April 1963, G.P.O. Washington D.C.
51. Fortner v Koch, 272 Mich. 373, 261 N.W. 762 (1935).
52. Jackson v Burton, 226 Ala. 483, 147 So. 414 (1933).
53. Bickford v Lawson, 27 Cal. App. 416, 81 P. 2d 216 (1938).
54. Lashley v Koerber, 26 Cal.2d 83, 156 P.2d 863 (1945).
55. George v Matthews, 346 P. 2d 863 (1959).
56. Harriott v Plimpton, 166 Mass . 585, 44 N.E. 992 (1896).
57. Meyers v Clarkin, 272 Mich. 273, 261 N.W. 762 (1935).
58. Johnson v Borland, 317 Mich. 225, 26 N.W. 2d 755 (1947).
59. Halverson v Zimmerman, 60 N.D. 113, 232 N.W. 754 (1930).
60. Shutan v Bloomenthal, 371 Ill. 244, 20 N.E. 2d 570 (1939).
61. Barber v North Shore Hospital, Inc., 145 So. 2d 760 (1962).
62. Lindsay v Michigan Mutual Liability Co., 156 So. 2d 313 (1963).
63. Lotspeich v Chance Vought Aircraft, 369 S.W. 2d 705 (1963).
64. Jefferson v United States, 340 U.S. 135, 71 S.Ct. 153 (1950).
65. Spath v Morrow, 115 N.W. 2d 581 (1961).

66. Davis v Kerr, 239 Pa. 351, 86 A. 1007 (1913).
67. Tiller v Van Pohle, 72 Ariz. 11, 230 P. 2d 213 (1951).
68. Young v Fishback, 262 F. 2d 469 (1958).
69. Fredrickson v Maw, 119 Utah 385, 227 P. 2d 772 (1951).
70. Swanson v Hill, 166 F. Supp. 296 (1958).
71. Fischer v Wilmington General Hospital, 51 Del. 554, 149 A. 2d 749 (1959).
72. Sherman v Hartman, 137 Cal. App. 2d 589, 290 P. 2d 694 (1955).
73. Erlichman v Feldheim, 231 N.Y.S. 2d 390 (1962).
74. Whitfield v Daniel Construction Co., 226 S.C. 37, 83 S.E. 2d 460 (1954).
75. Agnew v Larson, 82 Cal. App. 2d 176, 185 P. 2d 851 (1947).
76. Snyder v Pantaleo, 143 Conn. 290, 122 A. 2d 21 (1956).
77. Yorston v Pennell, 397 Pa. 28, 153 A. 2d 255 (1959).
78. Norton v Argonaut Insurance Co., cited at footnote 43.
79. James v Robertson, 39 Utah 414, 117 P. 1068 (1911).
80. Evans v United States, 319 F. 2d 751 (1963).
81. Ball Memorial Hospital v Freeman, 196 N.E. 2d 274 (1964).
82. State v Meiner, 41 N.J. 21, 194 A. 2d 467 (1963).
83. Cox v Hecker, 218 F. Supp. 749 (1963).
84. Ragin v Zimmerman, 206 Cal. 723, 276 P. 107 (1929).
85. Ferrara v Galluchia, 5 N.Y. 2d 16, 176 N.Y.S. 2d 996 (1958).
86. Hess v Rouse, 22 S.W. 2d 1077 (1929).
87. Favorala v Aetna Casualty and Surety Co., cited at footnote 35, Hillcrest Medical Center v Wier, cited at footnote 35.
88. Sanzari v Rosenfeld, cited at footnote 5.
89. Dohr v Smith, cited at footnote 25.
90. Lanier v Trammell, 207 Ark. 372, 180 S.W. 2d 818 (1944).
91. Mastro v Kennedy, cited at footnote 28.

92. United States v Brown, 348 U.S. 110, 75 S.Ct. 141 (1954).
93. Davis v Virginian Railway Company, 361 U.S. 354, 80 S.Ct. 387 (1960).
94. Hight v State, 231 N.Y.S. 2d 361 (1962).
95. Clary v Hospital Authority, 126 S.E. 2d 470 (1962).
96. Del Riccio v Montwill Corp. 230 N.Y.S. 2d 501 (1962).
97. Livingston v Portland General Hospital Ass'n, 357 P. 2d 543 (1960).
98. Mahoney v State, 230 N.Y.S. 2d 564 (1962); Aaronson v State, 229 N.Y.S. 2d 550 (1962).
99. Schreck v State, 231 N.Y.S. 2d 563 (1963).
100. Kolesar v United States, cited at footnote 30.
101. Evan v Roberts, 172 Iowa 653, 154 N.W. 923 (1915).
102. Goodwin v Hertzberg, 201 F. 2d 204 (1952).
103. Hammer v Rosen, 7 N.Y. 2d 376, 198 N.Y.S. 2d 65 (1960).
104. Flanagan v Smith, 197 Iowa 273, 197 N.W. 49 (1924).
105. Vale v Noe, 172 Wis. 421, 179 N.W. 572 (1920).
106. Whetstine v Morevec, 228 Iowa 352, 291 N.W. 425 (1940).
107. Dee v Beck, 141 So. 2d 920 (1962).
108. Composano v Claiborn, 2 Conn.Cir. 135, 196 A. 2d 129 (1963).
109. Johnson v Caldwell, 123 N.W. 2d 785 (1963).
110. Wilson v Kornegay, 132 S.E. 2d 791 (1963).
111. Vann v Harden, 187 Va. 555, 47 S.E. 2d 314 (1948).
112. United States V Ridolfi, 318 F. 2d 467 (1963).
113. Cramer v Osteopathic Hospital, 363 P. 2d 218 (1963).
114. Barcia v The Society of N.Y. Hospital, 241 N.Y.S. 2d 373 (1963).
115. Stone v Proctor, 131 S.E. 2d 297 (1963).
116. Horner v Northern Pac. Beneficial Assn Hosp., 382 P. 2d 518 (1963).
117. Fehrman v Smirl, 121 N.W. 2d 255 (1963).

## CHAPTER V

### Proof of Malpractice

U.C.

1. Introduction. Malpractice is not easily proven. The plaintiff has the burden of proof, (1) and proof of malpractice generally requires supporting testimony by expert witnesses. (2) It is only in the exceptional case that medical or dental negligence is so clear that it may be determined and understood by the ordinary layman, without the assistance afforded by expert testimony.

2. Burden of Proof. Before a plaintiff may recover damages in a malpractice action, he must prove his claim by a preponderance of the evidence. (3) A preponderance of the evidence means a superiority of weight, and weight of evidence connotes credibility and influence. (4) It is presumed that a physician has properly discharged his duty. (5) His negligence cannot be presumed from the mere happening of an unsuccessful result, (6) but must be affirmatively proved. (7)

In the absence of specific words to that effect, a physician does not guarantee a good result, nor does he impliedly warrant a cure or an accurate diagnosis. (8) Proof that a result is different from that expected, or that the treatment was followed by disastrous instead of beneficial results, neither establishes nor supports an inference of want of proper care, skill or diligence. (9) In the Army medical system, a physician is not, of course, authorized to bind the government by <sup>any</sup> contractual type of agreement, such as a guarantee of a cure or good result, and, even if he were to make such an agreement, his breach would not support a claim against the government under the Federal Tort Claims Act.

3. Proof by Expert Testimony. Malpractice actions usually involve questions of professional skill and attention as to which laymen cannot be expected to know the appropriate standards of care to be followed. (10) Therefore, it is the general rule that, in order to prove malpractice, the plaintiff must usually present expert testimony in his behalf. (11) Moreover, the testimony must show a probability, and not a mere possibility of causal connection between the acts complained of and the injury. (12)

As has been previously indicated, in presenting expert testimony, (13) the standards required to be followed by medical people are measured against those ordinarily followed by other similar types of medical people practicing in the same locality or community. The standards of the locality must be proved. It is not enough to show, for example, that another physician would have acted differently from the defendant, if it is not also shown that the other physician would have been following community practice. (14) Ordinarily, proof of local standards requires expert testimony.

The "locality" rule is compounded, to some extent, by the rule that requires the expert witness to be "of the same school of practice" as the defendant. Thus, in Scott v Leigh, (15) the court said that a patient has no cause of action against his physician for malpractice either in diagnosis or treatment, unless he can prove negligence <sup>the testimony of</sup> by a physician of the same school of practice as the defendant.

But, even the "same school of practice" rule has been modified in some cases to the extent that an expert witness, although not of the same school as the defendant, may testify regarding a procedure which would be considered negligent according to any school of practice. This is seen in a malpractice

action against a dentist, in which a physician was permitted to testify as to the standards of care to be used before giving anesthesia. (16) The court said: "It seems to us that in these areas where the medical and dental professions overlap, a physician familiar with the situation in issue is competent to testify to the accepted practice among dentists."

There is an interesting aspect of this in <sup>a</sup>Florida malpractice case where the expert witnesses were physicians from Chicago. <sup>(17)</sup> Their testimony was objected to as being improper in a case involving a Florida physician. In holding that there was no basis for objection, the court said: "Proximate cause does not change with the locality. The jury could have found, as a matter of their own common knowledge and experience, and independent of expert testimony as to acceptable medical practice, that the fingers and thumb of a premature infant were needlessly burned off, and that this could not be considered acceptable medical practice in any community."

The expert testimony which establishes the plaintiff's prima facie case may be that of the defendant when testifying, or testimony contained in his extrajudicial admission. In Lashley v Koerber, (18) the defendant's extrajudicial statements that he should have taken an X-ray, and "Yes ... I know it is not your fault ... it is all my own." were held to be prima facie admissions of negligence. In this case, the court said: "We can presume that defendant in testifying will state his case as favorably to himself as possible ... And extrajudicial admissions of defendant have the same legal competency as direct expert testimony to establish the critical aver<sup>ments</sup> of the complaint ... It is true that an extrajudicial statement amounting to no more than an admission of bona fide mistake of judgment or untoward result of treatment is not alone sufficient to permit the inference of breach of duty; the statement 'must be an admission of negligence or lack

of skill ordinarily required for the performance of the work undertaken."

In other cases, the following admissions were considered to be in favor of the plaintiff: A statement that the nurse left the radium on too long and that "it was my fault", (19) "Unfortunately I gave Mr. Callahan too much X-ray," (20) "Uh, uh, I have done the wrong thing." (21)

But, all the facts of a case must be taken into consideration, and that is seen from the following statements which were held to be no more than admissions of bona fide mistake or misfortune, and thus insufficient to establish negligence: "It was my fault", (22) a statement by the defendant that he had performed a "wrong operation", (23) a statement by the defendant that he "should never have administered an injection" and "that was what was causing" the plaintiff's pain, (24) "I nipped her bladder." (25)

The plaintiff's expert can also cause the plaintiff to lose his case. In Barber v North Shore Hospital, Inc., (26) the hospital was held to be not negligent in any failure to diagnose the infectious condition of the minor patient at the time of her discharge, because the plaintiff's own expert witness clearly indicated that the symptoms of the infection would not have been apparent during the time the child was within the confines of the hospital.

The testimony of expert witnesses is, however, merely advisory to the court, (27) and when there is a conflict between experts in a case, a court may evaluate the conflict, and reach its own decision. (28) Moreover, it has been held to be improper for an expert to express an opinion on the ultimate fact required to be determined by the court. (29) Thus, in Atkins v Humes, (30) the court said: "Many courts hold that it is improper

for an expert to testify that the alleged malpractice did occasion the result complained of as distinguished from expert testimony that the alleged malpractice could occasion the result. In this connection it has been said ... ' When a result could have been occasioned by one of two or more causes, the ultimate fact of which cause occasioned the result is for the determination by the jury, and a medical expert may not, in case of conflicting evidence, invade the province of the jury and testify that the result was in fact occasioned by one cause only.'"

4. Proof from Common Knowledge. Although it is the general rule in malpractice cases that expert testimony is required to establish standards of care and whether they were adhered to, an exception is made in those cases where, after the acts of the defendant practitioner have been shown, the matter under consideration is so simple, and the lack of skill or want of care is so obvious as to be within the range of ordinary experience and comprehension even of nonprofessional persons. In these types of cases, expert testimony is not required to guide the court or jury in the matter of applicable standards. (31)

In Sanzari v Rosenfeld, (32) Mrs. Sanzari visited the defendant dentist to have a filling replaced. The anesthetic injected into her gums was Xylocaine in combination with Epinephrine. When the defendant had finished working, Mrs. Sanzari had a stroke from which she died three days later. Mrs. Sanzari had been suffering from hypertension, and, according to the manufacturer's brochure, Epinephrine was contraindicated for her. It was not clear whether defendant had taken Mrs. Sanzari's medical history before injecting the anesthetic. The court said: "We believe it is within the common knowledge of laymen that a reasonable man, including a dentist, who knows a drug is potentially harmful to a certain type of patient should take

adequate precaution before administering the drug or deciding whether to administer it."

Dohr v Smith (33) was an action for damages for injury to a patient who swallowed two false teeth which were dislodged when an anesthetist inserted a tube into the patient to supply oxygen during an operation. The anesthetist had attempted to take all proper precautions preparatory to the operation, but "assumed" none of the patient's teeth was false. She had refrained from asking the patient if she had false teeth, because "the question would be insulting." The court said: "We do not think the (patient) should be defeated simply because no expert testified that what happened in this case amounted to negligence on the part of the anesthetist. To repeat, the very caution she undertook to exercise undermines her position. The jury could have decided from common knowledge and experience, regardless of expert testimony, that the patient needlessly suffered from a condition the anesthetist herself sought to prevent."

In other cases, it has been held that, in the exercise of only common sense and judgment, and without the need for expert testimony, a court or jury would have the right to conclude that it is negligence:

- a. To permit a wound to heal superficially with nearly half a yard of gauze deeply embedded in the flesh. (34)
- b. To fail to sterilize surgical instruments before performing an operation. (35)
- c. To cut off part of a patient's tongue in removing adenoids. (36)
- d. To perforate the urethra while performing an operation in which it was necessary to use care not to do so. (37)
- e. To leave a gauze pad in a patient following an operation (38).

f. To use an unsterile hypodermic needle in administering an anesthetic. (39)

g. To spill acid in a patient's eye while removing a cyst from the eyelid. (40)

h. To cause an upper right lateral incisor to come out while removing a lower left second molar. (41)

i. To beat a patient while giving her psychiatric treatment. (42)

j. To fail, as a nurse, in following the physician's written instructions. (43)

k. To leave medical supplies in an incision. (44)

l. To burn and shock a patient while using an X-ray machine. (45)

Looking into the future, it might be interesting to speculate, with increasing information being passed to the public by radio, television, magazines and the like, whether the courts will expand the categories as to which laymen will be allowed to reach conclusions based on "common knowledge". That this time probably has not yet come is indicated in a 1959 case in which the court said: "It certainly is not within the common knowledge of a layman as to how tight a cast should be applied to a foot following a 'triple arthrodesis' operation." (46)

5. Res Ipsa Loquitur (47). Res ipsa loquitur is a rule of circumstantial evidence which permits a court to draw an inference of negligence in a malpractice suit, where the facts are such that it is reasonable to infer that, under the circumstances, the injury to the plaintiff would not have ordinarily occurred in the absence of defendant's negligence.

Res ipsa loquitur is a doctrine applicable to the law of negligence generally. It is not limited to malpractice actions, and, in some juris-

dictions, it is not applied. (48) It is not a new doctrine, although its broad application in malpractice cases is of comparatively recent origin. (49) ~~The rule exists because it is needed in the proper administration of justice.~~

As the law of negligence developed, lawyers and the courts discovered that, on occasion, people were injured under circumstances which indicated negligence of others, but that they were unable to obtain witnesses to testify on their behalf in court. In some cases, there were no witnesses. In some cases, the only witness other than the plaintiff was the defendant, who would not testify for the plaintiff. In some cases, there were witnesses whom the plaintiff did not dare call because they were friendly to the defendant and might bind the plaintiff with unfavorably false or slanted testimony. In some cases, even the injured party did not know what had motivated the occurrence that had caused the injury -- he could prove what had resulted, but not how or why. In connection with the foregoing, the following language from Christie v Callahan (50) is pertinent: "Malpractice is hard to prove. The physician has all the advantage of position."

The doctrine of res ipsa loquitur may be applicable in malpractice cases when both of the following elements are present: (51)

a. The injury was one which ordinarily does not happen unless someone is negligent, and

b. The instrumentality or agency which caused the injury was under the exclusive control of the defendant. (52)

The doctrine of res ipsa loquitur is related to the "common knowledge" doctrine, although the difference is not always seen. In attempting to explain the distinction, the court said, in Sanzari v Rosenfeld: (53)

"The doctrine of 'common knowledge' is related to res ipsa loquitur, but there is a distinction between the two. In res ipsa cases, plaintiff need only prove his injury, and need not prove a standard of care or a specific act or omission. Ordinarily, the common knowledge doctrine is applied in a malpractice case after the plaintiff proves his injury and a causally related act or omission by the defendant. The affect of applying this doctrine is to allow the jury to supply the applicable standard of care and thus to obviate the necessity for expert testimony relative thereto. In other words, application of the doctrine transforms the case into an ordinary negligence case where, as mentioned above, the jury, from its fund of common knowledge assays the feasibility of possible precautions which the defendant might have taken to avoid injury to the plaintiff. The basic postulate for application of the doctrine therefore is that the issue of negligence is not related to technical matters peculiarly within the knowledge of medical or dental practitioners." (54)

Under the doctrine of res ipsa loquitur the plaintiff is able to establish a prima facie case of malpractice by proof of the injury and the surrounding circumstances. As indicated above, he does not have to prove a specific act or omission of the defendant. The procedural effect of applying the doctrine is that proof of certain physical facts will permit a court to infer negligence, so as at least to avoid a dismissal at the end of the plaintiff's case. Proof of these physical facts does not, however, compel a judgment for the plaintiff, because the defendant has an opportunity to explain them away.

The doctrine is not an arbitrary rule, but is rather a commonsense appraisal of the value of circumstantial evidence, and is a rule of reasonable inferences. (55) Moreover, an inference of negligence is made

only when it is both reasonable (56) and a logical deduction from proven facts, as opposed to supposition, conjecture or guesswork. (57) For example, the mere fact that an unsuccessful result has followed medical treatment does not, in itself, establish an inference of negligence that would permit application of the doctrine of res ipsa loquitur. (58)

In Donoho v Rawleigh, (59) it was held that the mere fracture of a jawbone by a dentist while removing an impacted wisdom tooth did not infer negligence or require application of res ipsa loquitur (60).

In Blodgett v Nevins, (61) it was held that in an action for alleged malpractice in extracting a tooth, whereby a fracture of the jaw resulted, the burden rested on the plaintiff to show want of care or skill on the part of the defendant and that the bad result following the treatment was the result of such want of care and skill. The court would not presume that the defendant was unskillful or negligent solely from the fact that the jaw was fractured and the plaintiff was otherwise uninjured.

In Flanagan v Smith (62), a dentist removed an impacted tooth and the resulting wound became infected. It was held that since there was evidence that infection sometimes occurs notwithstanding every precaution, there would be no presumption of negligence on the defendant's part arising from the infection alone.

In Vale v Noe, (63) a dentist was preparing a tooth for a crown when the electrically operated stone or disc with which he was grinding the tooth slipped and cut the patient's mouth and tongue. It was held that the burden was on the plaintiff to prove that the cut was the result of the defendant's negligence, and that negligence of the dentist could not be inferred from the circumstances, there being no room for the application of the doctrine of res ipsa loquitur. (64)

In McKeever v Phoenix Jewish Community Center, (65) the court said that the "doctrine of res ipsa loquitur is simply a rule of circumstantial evidence and gives rise to an inference of responsibility for an injury. There is no magic attached to utterance of the phrase. In going forward with his proof, plaintiff must still prove proximate cause and show that no injury would have resulted but for some sort of negligence on the part of the defendant. In addition, he must prove that the instrumentality causing the injury was in the exclusive control of the defendant at the time of the injury." (66)

Thus, the doctrine does not disturb the general rule in lawsuits that the plaintiff has the burden of proof and must sustain his action by a preponderance of the evidence. According to the majority view, application of the doctrine does not shift the burden of proof. (67)

In determining the probabilities that may exist with regard to a particular occurrence, the courts vary in applying the doctrine when expert testimony in addition to circumstantial evidence is available to the plaintiff. Most courts apply the rule only when expert testimony is not available.

But, there is a basic limitation on application of the doctrine in malpractice cases: The doctrine will not be applied if the factors involved are so technical that ordinary laymen are not competent to reach a proper conclusion without the assistance of expert testimony.

As the doctrine is applied in malpractice cases, the fact that a particular injury suffered by a patient as a result of an operation is something that rarely occurs does not in itself prove that the injury was probably caused by the negligence of those in charge of the operation. (68)

Silverson v Weber (69) was an action against surgeons for malpractice and negligence in performing a hysterectomy, in which plaintiff alleged that a fistula developed after the operation. Plaintiff did not call an expert witness, but attempted to rely on the doctrine of res ipsa loquitur. The court rejected this, and quoted from Dees v Pace (70) as follows: The undisputed expert testimony shows that a fistula is a recognized hazard in all hysterectomies, one of the calculated risks; and while it does not occur very often from any cause, it may occur where the operation is performed under ideal conditions by the most skillful surgeon without negligence on his part."

To permit an inference of negligence under the doctrine of res ipsa loquitur solely because an uncommon complication develops would place too great a burden on the medical and dental professions, and might result in an undesirable limitation on the use of operations or new procedures involving an inherent risk of injury even when due care is used.

Where risks are inherent in an operation, and an injury of a type which is rare does occur, and could occur even if the operation were performed carefully and in accordance with proper practice, the doctrine should not be applicable unless it can be said that, in the light of past experience, such an occurrence is more likely the result of negligence than some cause for which the defendant is not responsible. This is illustrated in the following cases:

a. In Whetstine v Moravec (71), Mr. Whetstine visited defendant, an exodontist, for the purpose of having teeth extracted. The doctor placed him under a general anesthesia, and he was completely oblivious as to what was happening. In connection with the extractions, the defendant permitted the root of a tooth to fall down the defendant's throat and windpipe, and

lodge in his right lung. Defendant failed to tell the plaintiff of this incident. After the extraction, plaintiff suffered seriously from spells of hard coughing, but did not understand the basis until nine months later. At that time, he had an especially severe spell of coughing, and coughed up the root of the tooth. In a suit for malpractice, the court held that the doctrine of res ipsa loquitur was applicable because: 1. The dental operation in the extraction of plaintiff's teeth was exclusively under control of the defendant, in view of the anesthesia and, 2. The accident to the plaintiff was such that, in the ordinary course of dental practice, it would not have happened had the defendant exercised usual and proper care in extracting the teeth.

b. In Ybarra v Spangard (72), plaintiff entered the hospital for an appendectomy, and was under anesthesia when the operation was performed. Prior to the operation, he had never had any pain in, or injury to his right arm or shoulder, and this arm and shoulder had not been the subject of treatment in the operation. When plaintiff awakened after the operation, he felt a sharp pain about half way between the neck and the point of the right shoulder. The pain spread down to the lower part of his arm, and after his release from the hospital, he developed paralysis and atrophy of the muscles around the shoulder. An area of diminished sensation developed below the shoulder, and a wasting away of the muscles followed. The plaintiff was able to show the injury only - he could not show how it happened. Thus, he sued not only the surgeon but also some of the hospital employees. The defendants argued that plaintiff did not show that the injury had been caused by an instrument under the exclusive control of any particular defendant. In holding that the doctrine of res ipsa loquitur

was nevertheless applicable, the court said: "... if we accept the contention of defendants herein, there will rarely be any compensation for patients injured while unconscious. A hospital today conducts a highly integrated system of activities, with many persons contributing to their efforts. There may be preparation for surgery by nurses and internes who are employees of the hospital; administering of an anesthetic by a doctor who may be an employee of the hospital, an employee of the operating surgeon, or an independent contractor; performance of an operation by a surgeon and assistants who may be his employees, employees of the hospital or independent contractors; and post surgical care by the surgeon, a hospital physician, and nurses. The number of those in whose care the patient is placed is not a good reason for denying him all reasonable opportunity to recover for negligent harm. It is rather a good reason for re-examination of the statement of legal principles which supposedly compel such a shocking result."

c. In Frost v Des Moines Still College of Osteopathy and Surgery, (73) plaintiff was anesthetized for an operation on her back. When she regained consciousness, she found that she had severe burns on her abdomen. In affirming a judgment for the plaintiff, the court applied the doctrine of res ipsa loquitur, as in the Ybarra case, and said: "We think it is a just and logical conclusion that one who, while undergoing a surgical operation, sustains an unusual injury to a healthy part of his body not within the area of the operation, be not precluded from invoking the doctrine of res ipsa loquitur in an action against the doctors and nurses participating in the operation. The same thing must be said of the corporate hospital regarding its preceding or subsequent care of the patient. This is not altered by the fact that all the parties do not stand in such relation to

one another that the acts of one may be regarded as the acts of the other, and that the injury may have been caused by the separate acts of any one of them, or by the fact that there were several instrumentalities and no showing as to which caused the injury or as to the particular defendant in control of it."

d. In Dee v Beck, (74) res ipsa loquitur was held to be applicable because there was injury to the patient's teeth while she was under general anesthesia for the purpose of abdominal surgery.

6. Defending Army Malpractice Litigation. When an action against the government is commenced for damages from alleged malpractice in an Army medical facility, the Department of Justice assumes top level responsibility for defense of the case. The actual courtwork and trials are generally handled by local United States attorneys, but, occasionally, the malpractice unit in the Department of Justice has one of its members prepare and try the case.

The Army furnishes liaison to the Department of Justice in these cases through the Office of The Judge Advocate General of the Army, who is the chief legal adviser in the Army. This liaison includes initial preparation of the Army's case, arrangements for the attendance of witnesses at trials and other proceedings, and such other matters as to which the Department of Justice may request assistance.

The Surgeon General of the Army acts in these cases as the medico-legal consultant to The Judge Advocate General of the Army and the Department of Justice. Theoretically, The Surgeon General and his staff are supposed to work with the Department of Justice through The Judge Advocate General. As a practical matter, they work directly with the Department of Justice

when it is more convenient to do so.

In the Office of The Surgeon General, two elements are most directly involved in handling malpractice cases: The office of the Judge Advocate and the Directorate of Professional Services.

The office of the Judge Advocate is a separate office in the Office of The Surgeon General that specializes in, among other things, medicolegal matters.

The Directorate of Professional Services is headed by a Director who is usually a specialist in internal medicine -- a specialty that requires a broad knowledge of the field of medicine. The Director has a staff of senior medical officers who are experts in various special fields of medicine, such as surgery, ophthalmology and psychiatry. Not all types of specialists are assigned to his office, but he has available to him expert consultants in the other fields of medicine, wherever they may be located. Generally, when he uses outside consultants, he uses those stationed at Walter Reed Army Medical Center, as a matter of convenience, but, if necessary, he may call upon a world wide staff. In the consultant field, the staff of the Armed Forces Institute of Pathology deserves special mention.

In every malpractice case, at some time before trial or settlement, the complete litigation file and all the medical records are sent to The Surgeon General for review, opinion and recommendation. The time when this is done may vary, from case to case, depending on the circumstances. Usually, however, the papers are received in an early stage of the litigation so that The Surgeon General's views may serve as a guide in handling the case.

The files and records are sent directly to the Judge Advocate's office by The Office of The Judge Advocate General. Occasionally, with the transmittal, the latter office will pose specific medicolegal questions to which it would

like answers, or it may forward specific questions from the Department of Justice. The Surgeon General is not limited to answering these questions and, in fact, it may be decided, after a review of the case in his office, that the questions are irrelevant or unimportant in the light of the medical aspects of the case. Or The Surgeon General may point out other or additional questions not raised in the transmittal.

The Judge Advocate then makes a preliminary review of the case, and, where necessary, calls for additional records. After the preliminary review has been completed in the office of the Judge Advocate, the entire file is sent to the Director of Professional Services. The transmittal will request his views on the medical aspects of the case, will point out the questions transmitted by The Judge Advocate General, and may add additional questions.

In the office of the Director of Professional Services, the entire file of medical and legal papers is reviewed by specialists or consultants in each field of medicine that may be involved in the particular case. This not only affords the broadest review possible, but also gives the specialists and consultants a familiarity with the case which could be invaluable if they should later be called as witnesses at the trial.

The review may be a lengthy procedure, particularly if consultants are located outside of Washington, or when there are differences of opinion, but the time and trouble are worthwhile because a thorough review is part of thorough preparation for litigation.

During the medical review, the specialists involved contact the legal office <sup>of the Judge Advocate</sup> when clarification of problems is needed, or to submit ideas, or to ask legal questions. When the medical review has been completed, members of the legal office and representatives of the Director of Professional Services meet to prepare a presentation of the recommended group's position on the case, from a medicolegal standpoint.

Consultation between the office of the Judge Advocate and the Directorate of Professional Services usually involves presentation of the medical and professional aspects of the case by the medical people, with "cross examination" by the lawyers, in order to arrive at a true medicolegal position that can be supported by the government. The diagnosis, medical procedures, the acts complained of and the results are not only considered from a medical standpoint but are also placed in the framework of applicable law, the final objective being to determine whether the claimant is right or wrong.

Thus, not every case will be considered to be defensible by the government. In fact, on occasion, The Surgeon General may recommend that a settlement be made.

After the Office of The Surgeon General has developed a conclusion in the case, a medical opinion is sent to The Judge Advocate General. This will include answers to the specific questions previously forwarded as well as additional points considered important following the conferences held in the Office of The Surgeon General.

The medical opinion is further transmitted to the Department of Justice which, on review, may have further questions. Then, additional conferences may be held among The Surgeons General's lawyers and lawyers of the Department of Justice and the Office of The Judge Advocate General. Sometimes the medical specialists participate in these conferences.

At some point, if the case is considered defensible by the government, the Office of The Surgeon General will assist in the selection of medical witnesses to testify as experts for the government.

## NOTES

1. Donoho v Rawleigh, 230 Ky. 11, 18 S.W. 2d 311 (1929).
2. Mastro v Kennedy, 57 Cal. App. 2d 499, 134 P. 2d 865 (1943); Roberts v Parker, 121 Cal. App. 264, 8 P. 2d 908 (1932), Oleksiw v Weidener, 195 N.E. 2d 813 (1964).
3. Edmunds v Ripley, 172 Neb. 797, 112 N.W. 2d 335 (1961); Demchuk v Bralow, 404 Pa. 100, 170 A. 2d 868 (1961); State v Housekeeper, 70 Md. 162, 16 Atl. 382 (1889).
4. Brown v Ceco Steel Products, 136 So. 2d 161 (1962).
5. Lane v Calvert, 215 Md. 457, 138 A. 2d 902 (1958). In Blackledge v Industrial Outdoor Displays, Inc., 145 So. 2d 53 (1962) the court said: "Plaintiffs counsel makes much of the fact that all of the doctors who treated the plaintiff were company doctors or doctors called by the company for consultation, and all were paid by the company. While this fact is true, it is not enough, standing alone, to disqualify their testimony, or cast suspicion on their professional character. A doctor's first obligation is to his patient, and unless evidence is introduced to the contrary, it must be assumed that these men performed their obligations in accordance with their oath."
6. Redwood v Raskind, 350 S.W. 2d 414 (1961); Jeffreys v City of Burlington, 256 N.C. 222, 123 S.E. 2d 500 (1962).
7. Lashley v Koerber, 26 Cal. 2d 83, 156 P. 2d 441 (1945).
8. Lagerpusch v Lindley, 115 N.W. 2d 207 (1962); Christie v Callahan, 124 F. 2d 825 (1941); Donaldson v Naffucci, 397 Pa. 584, 156 A. 2d 835 (1959).
9. Wall v Brim, 138 F. 2d 478 (1943); Colvin v Hunter, 374 P. 2d 421 (1962).
10. Christian v Wilmington General Hospital, 11 Terry 550, 135 A. 2d 727 (1957); Michael v Roberts, 91 N.H. 499, 23 A. 361 (1941). See, also, Chapter IV.
11. Carrigan v Roman Catholic Bishop, 104 N.H. 73, 178 A. 2d 502 (1962); Atkins v Humes, 110 So. 2d 663 (1959); Zotorell v Repps, 187 Mich. 319, 153 N.W. 692 (1915); In re Look's case, 185 N.E. 2d 626 (1962); Marsh v Pemberton, 10 Utah 2d 40, 347 P. 2d 1108 (1959).
12. Drakulich v Industrial Commission, 137 Ohio St. 82, 27 N.E. 2d 932 (1940). ~~Chapter IV~~ On the subject of when a man is an expert and when he may be permitted to testify, see Jenkins v United States, 307 F. 2d 637 (1962).
13. See Chapter IV.
14. Lane v Calvert, cited at footnote 5.
15. 355 S.W. 2d 798 (1962).
16. Sanzari v Rosenfeld, 34 N.J. 128, 167 A. 2d 625 (1961).

17. *Montgomery v Stary*, 84 So. 2d 34 (1959).
18. 26 Cal. 2d 83, 156 P. 2d 441 (1945).
19. *Scott v Sciaroni*, 66 Cal. App. 577, 226 P. 827 (1924).
20. *Christie v Callahan*, cited at footnote 8.
21. *Wall v Brim*, cited at footnote 9.
22. *Phillips v Powell*, 210 Cal. 39, 290 P. 441 (1930).
23. *Markart v Ziemer*, 67 Cal. App. 363, 227 P. 683 (1924).
24. *Donohos v Lovas*, 105 Cal. App. 705, 233 P. 698 (1930).
25. *Modrzynski v Lust*, 88 N.E. 2d 76 (1949).
26. 145 So. 2d 760 (1962).
27. *Atkins v Humes*, cited at footnote 11.
28. *Guest v Breedin*, 257 F. 2d 22 (1958). Cf. *Bowker v State*, 373 P. 2d 500 (1962), *State v Doyle*, 186 A. 2d 499 (1962).
29. *McClees v Cohen*, 158 Md 60, 148 A. 124 (1930)
30. Cited at footnote 11.
31. *Robinson v Wirts*, 387 Pa 291, 127 A. 2d (1956). See, also, *Ballance v Dunnington*, 241 Mich. 383, 217 N.W. 329 (1928).
32. Cited at footnote 16.
33. 104 So. 2d 29 (1958).
34. *Walker Hospital v Pulley*, 74 Ind. App. 659, 127 N.E. 554, 128 N.E. 933 (1920).
35. *Lanier v Trammell*, 180 S.W. 2d 818 (1944).
36. *Evans v Roberts*, 172 Iowa 653, 154 N.W. 923 (1915).
37. *Goodwin v Hertzberg*, 201 F. 2d 204 (1952).
38. *Davis v Kerr*, 239 Pa.351, 86 A. 1007 (1913), *Russell v Newman*, 115 Kan 268, 226 P. 752 (1924), *Barham v Widing*, 210 Cal. 206, 291 P. 173 (1930).
39. *Mastro v Kennedy*, 57 Cal. App. 2d 499, 134 P. 2d 865 (1943).
40. *James v Robertson*, 39 Utah 414, 117 P. 1068 (1911).
41. *Steinke v Bell*, 32 N.J. Super, 67, 107 A. 2d 825 (1954).

42. Hammer v Rosen, 7 N.Y. 2d 376, 198 N.Y.S. 2d 65 (1960).
43. Larrimore v Homeopathic Hospital, 181 A. 2d 573 (1962).
44. Marsh v Pemberton, cited at footnote 11.
45. Ragin v Zimmerman, 206 Cal. 723, 276 P. 107 (1929).
46. Marsh v Pemberton, cited at footnote 11.
47. Literally translated: "The think speaks for itself".
48. Roberts v Wood, 206 F. Supp. 579 (1962).
49. The origin of the doctrine is described in Horner v Northern Pacific Beneficial Association Hospitals, 382 P. 2d 518 (1963).
50. Cited at footnote 8.
51. Lagerpusch v Lindley, cited at footnote 8, Honea v Coca Cola Bottling Co., 143 Tex. 272, 133 S.W. 2d 968 (1944), Gratton v Fitch, 352 S.W. 2d 902 (1961).
52. For a modification of the element, see Ybarra v Spangard, cited below, at footnote 72.
53. Cited at footnote 16.
54. The omission to draw a distinction between the two doctrines is shown in the following language from Robinson v Wirts, cited at footnote 31:  
"... no presumption or inference of negligence arises merely because the medical care or surgical operation terminated in an unfortunate result which might have occurred even though proper care and skill had been exercised, and where the common knowledge or experience of laymen is not sufficient to warrant their passing of judgment. In such cases, the doctrine of res ipsa loquitur ... may not be invoked, and expert testimony in support of the plaintiff's claim is an indispensable requisite to establish a right of action." (emphasis supplied).
55. Phillips v Union Electric Co., 350 S.W. 2d 432 (1961).
56. Christie v Callahan, cited at footnote 8.
57. Mitchell v Machinery Center, Inc., 297 F. 2d 883 (1961).
58. Lane v Calvert, cited at footnote 5.
59. Cited at footnote 1.
60. Similar cases are Hopkins v Haller, 59 Cal.App 447, 210 P. 975 (1922) and Donoghue v Shaw, 170 Mich. 544, 136 N.W. 367 (1912).

61. 139 Ill. App. 544.
62. 197 Iowa 273, 197 N.W. 49 (1924).
63. 172 Wis. 421, 179 N.W. 572 (1920).
64. But, see *Dux v Shaver*, 105 Pa. Super. 344, 161 A. 481 (1932), where, in a similar case, the "common knowledge" doctrine was applied.
65. 374 P. 2d 875 (1962).
66. See, however, *Ybarra v Spangard*, cited below at footnote 72.
67. *Swanson v Murray*, 172 Neb. 839, 112 N.W. 2d 114 (1961).
68. *Siverson v Weber*, 57 Cal. 2d 834, 372 P. 2d 97 (1962).
69. 57 Cal. 2d 834, 372 P. 2d 97 (1962).
70. 118 Cal. App. 2d 234, 257 P. 2d 756 (1953).
71. 228 Iowa 352, 291 N.W. 425 (1940).
72. 25 Cal. 2d 486, 154 P. 2d 687 (1945).
73. 248 Iowa 294, 79 N.W. 2d 306 (1956), rehearing denied 1957.
74. 141 So. 2d 920 (1962).

## Chapter VI

### CONSENT TO MEDICAL PROCEDURES

1. Introduction. In Schloendorff v Society of New York Hospital, (1) the New York Court of Appeals said, in 1914: "Every human being of adult years has a right to determine what shall be done with his own body ..." Consistent with this statement, it is usually considered that there is an assault, (2) and assault and battery, (3) or a battery (4) when a physician renders medical care to a patient without the patient's consent or beyond the scope of his consent. Only a minority of the jurisdictions consider this to be malpractice. (5) If medical treatment includes restraint of a patient without proper consent, as might be the case with a psychotic patient, a cause of action could also include a claim of damages for false imprisonment. (6) And, it should be noted, an assault and battery could also be the basis for criminal charges under appropriate circumstances. The right of a person to determine whether to submit to recommended medical treatment or surgery includes his right expressly to prohibit life-saving medical care, ~~(7)~~ but it is not certain that this right would be upheld in all instances by the courts. In this connection, a federal court has required a patient to submit to life-saving blood transfusions despite his religious objections.

The label used to describe a claim involving unconsented to medical procedures, i.e., assault, assault and battery or battery, depends upon the jurisdiction, or on the writer of the decision in the particular case. Whichever label is used, the gravamen of the claim is the fact that there has been an unauthorized touching of a patient by a physician. Proof of negligence (7) or intent to injure (8) is not considered relevant. By the

same token, contributory negligence or improper conduct on the part of the patient are not available as defenses. For example, in Schmeltz v Tracy, (9) which was an assault case against a dermatologist based on unauthorized treatment, the court held it to be no defense that the patient had picked the scabs on her face and thus had aggravated her injuries. And, in Hancock v Hulett, (10) a father's action against a surgeon for having performed an illegal abortion on his minor daughter was not defeated by the fact that the daughter had consented to the operation. On the question of proof of consent to medical procedures, the courts are not in accord whether the patient has the burden of proving lack of consent or whether the physician has the burden of proving that consent was given. (11)

As has been indicated in Chapter III, the Federal Tort Claims Act does not authorize a claim for damages against the government based on assault and battery. Nevertheless, it is not certain that an individual Army physician would be similarly protected, except <sup>probably,</sup> in a case involving a military person on active duty. (12) In view of this uncertainty regarding non-military patients, and to protect individual Army physicians against the possibility of suits for damages based on assault, Army Regulations (13) spell out, in some detail, policy as to obtaining consent to medical procedures to be performed on non-military patients.

2. Implied and Express Consents, Generally. When a patient is legally capable of giving consent to medical procedures, his consent may either be implied or specifically expressed.

a. Implied consent. An implied consent may be construed from actions of the patient or other circumstances, even though specific words of consent or agreement are not spoken or written. In the routine case of medical

treatment, when a patient visits a medical facility for necessary care, there usually is no agreement or consent spelled out in detail. For example, a patient's application for admission to a hospital is an implied consent to hospitalization; if a patient is a minor incapable of giving consent on his own behalf, the implied consent of the parent to treatment may be found in actions of the parent in requesting or not objecting to medical care for the minor. The scope of the treatment is usually implied as being that which will be necessary, and it is accepted by the patient on the basis of his confidence in the skill of the physician. (14) This may be an oversimplification, but it is usually the situation where risks are small or practically nonexistent; in some cases, if a physician were to go into great detail and require an express consent even in a simple case, the details could unnecessarily frighten the patient and deter him from undergoing needed care.

b. Express Consent. Although, in most cases, an implied consent is sufficient authorization to furnish medical care, there are occasions when a more or less exact agreement should be made in advance of medical treatment. This is recommended not only to protect the medical practitioner, but also to guide the patient. The requirement for such an agreement would be particularly cogent if treatment will involve a real risk of an unsatisfactory result, where a major surgical or medical procedure is proposed, or where a patient is a potential trouble-maker.

Basically, an express consent involves an interchange of language between a physician and a patient, or person authorized to act on his behalf, in which the latter specifically agrees to proposed medical care. An express consent may be valid whether it is oral (15) or in writing, but, when it is considered necessary to have one, it should be in writing.

The form which a written consent should take is not of great importance from either a medical or a legal standpoint. The important aspects of a consent are its substance and the propriety of its execution. When executed, a consent should contain sufficient information so that it will

(a) Record and identify for the future the scope of the treatment or procedures consented to, (16)

(b) Record that the party consenting has the legal authority or capacity to consent,

(c) Record that the patient or his authorized representative has been informed, and understands the procedures proposed and at least some of the possible consequences, and

(d) Avoid the possibility that the patient may claim assault, false imprisonment, misrepresentation, or the like.

c. Standard Form 522. Standard Form 522 (Clinical Record - Authorization for Administration of Anesthesia and for the Performance of Operations and Other Procedures) is a printed form, used throughout the federal government, as a means of recording consents to medical procedures. In the Army, it is required to be used in connection with the following, when nonmilitary patients (both inpatients and outpatients) are involved:

(a) All major and minor surgery which involves an entry into the body, either through an incision or through one of the natural body openings.

(b) Any procedure or course of treatment in which anesthesia is used, whether or not an entry into the body is involved.

(c) All nonoperative procedures which involve more than a slight risk of harm to the patient, or which involve the risk of a change in the patient's body structure.

(d) All procedures where roentgen ray, radium or other radioactive

substance is to be used in the treatment of the patient.

(e) All procedures which involve electroshock or insulin coma therapy.

(f) Admission of patients with psychotic disorders.

(g) Admission of patients to closed psychiatric wards.

(h) All other procedures which, in the opinion of the attending physician or dentist, Chief of Service, or the medical facility commander require a written consent. Any question as to the necessity or advisability of obtaining a written consent is to be resolved in favor of obtaining such a consent.

If consent for dental procedures which fall under (a) or (b) above, is obtained at the commencement of a course of treatment, only one Standard Form 522 will be required.

The form should be personally signed by the patient or by the person authorized to act on his behalf.

3. Who Must Consent. a. General Law. A patient should not be furnished with medical care without either his consent or the consent of a person who is authorized to consent on his behalf under local law<sup>✓</sup> pursuant to the order of a court having jurisdiction<sup>^</sup> over both the patient and the facility concerned. This rule applies even though a person is entitled by law to medical care in Army medical treatment facilities.

This statement indicates that there may be occasions when, even without the consent of the patient himself, consent may be imposed by law, governmental authority, or otherwise. Instances of this are shown in statutes requiring compulsory inoculations (17) or those which provide for the sterilization of mental incompetents. (18) In addition, consent to medical procedures may be

given on behalf of infants or incompetents by their parents or guardians, (19) a court may direct that medical procedures should be performed on an infant without the consent of his parent, (20) a soldier may be required to submit to certain procedures by Army physicians, (21) or, in an emergency, the consent of a patient may be considered imposed upon him if he is incapable of giving or denying consent, and his condition represents an imminent threat to his life, health or well-being. (22) Moreover, pursuant to the provisions of an insurance policy, an insured claiming compensation for physical injury may be required to submit to a physical examination by the insurance company's physician, or a person seeking employment may be required to submit to a pre-employment physical examination by a prospective employer's physician. And, there is a large category of persons who, as claimants under various types of Workmens Compensation Acts or company insurance plans are required to be examined and treated by physicians not of their choice.

b. Army Requirements. In order for a consent to be valid, it must be given by a person legally capable of giving the consent, except in an emergency. Whose consent will be required will depend upon the law of the state concerned. Nevertheless, the following broad rules of guidance are followed in the Army.

If a nonmilitary patient is an unmarried minor, consent will ordinarily be obtained from the patient's parent or guardian. When parental consent is required, it is preferable to obtain the father's consent, if feasible. In addition, it is advisable to obtain the consent of the minor, if he is a person of understanding and maturity. In some cases, the consent of the minor alone may be sufficient, if he is mature enough to be able to understand and fully comprehend the significance of the procedures contemplated. (23)

Normally, and except in an emergency, (24) the consent of an adult member of the family other than a parent is insufficient, if the minor's parents are alive. (25) And this is so even if the minor is living with the adult relative, away from his parents, unless the relative also has legal custody of the minor.

Depending upon the law of the state involved, a married minor may be considered to be emancipated, and capable of giving a valid consent without the added consent of her parents or guardian. The question of emancipation could arise where medical procedures are contemplated as to a minor wife entitled to medical care in Army medical facilities.

Despite the fact that an implied consent is usually considered to be present in emergency situations, medical care should not be given even in an emergency to an unemancipated minor if the parent or guardian expressly or impliedly objects. In some instances, however, where the need for medical care of a minor is obvious but consent thereto is withheld by his parents or guardian, a court may intercede on behalf of the infant, and direct that medical care be given. This sort of situation might arise where, for example, a parent for religious reasons, might refuse permission to give a blood transfusion to a minor. (26)

When a non-military patient is an adult, but is unable to consent for some reason other than mental incompetency, the consent of the spouse or next of kin should be obtained, except in an emergency situation. When a wife is a patient capable of given consent, the consent of the husband alone is not sufficient. Normally, it is not necessary to obtain a husband or wife's consent for medical procedures to be performed on the other, although it is advisable to obtain the consent of both spouses to procedures which may affect the sexual or life-giving capacities of the other. State v Housekeeper (27)

was a case in which a husband sued for damages for the death of his wife following a mastectomy to which only she had consented. In denying the husband's claim, despite the absence of his consent, the court said:

"Surely the law does not authorize the husband to say to his wife: 'You shall die of cancer, you cannot be cured, and a surgical operation affording only temporary relief will result in useless expense.' The husband had no power to withhold from his wife the medical assistance which her case might require."

When a nonmilitary patient has been judicially determined to be incompetent, consent for medical procedures must be obtained from the individual appointed by the court to act for the incompetent, except in an emergency.

Even in the absence of an appropriate court order or the consent of a patient or person authorized to act on his behalf, the commander of an Army medical facility may temporarily detain a non-military individual who has a psychiatric disorder that makes him dangerous to himself or to others, when he is found on the military reservation where the medical facility is located, or when there is a real emergency requiring that the individual, even though found off the reservation, should be temporarily detailed in that facility. In such a case, if proper consent to or authorization for admission to the facility cannot otherwise be obtained, the local civilian authorities should be notified immediately, and the individual should be transferred to those authorities.

4. The Informed Consent. One of the elements affecting the validity of a consent is whether the person giving the consent understands what he is consenting to, and, to a sufficient degree, understands the possible consequences of the procedure for which consent is being given. The physician who

is to perform or supervise the performance of treatment or a procedure should counsel the patient or other consenting individual as to the nature of the proposed treatment or procedure, its risks and possible results. When counseling is given in connection with the execution of Standard Form 522, the counselor is required to indicate this on the form.

Counseling the patient or other consenter is an area which requires judgment and discretion. In some cases, telling the patient too much could be more harmful than telling him too little. In Woods v Brumlop, (28) the court stated that without full and frank disclosures to a patient by his physician relative to his illness and the treatment prescribed or recommended, any consent obtained from the patient for the administration of that treatment would be ineffectual. The court added, however, that a physician is not required to disclose the dangers of treatment to a patient where there is an actual emergency and the patient is in no condition to determine for himself whether the treatment should be administered.

This has been well considered in Salgo v Leland - Stanford Trustees (29), where it was said: "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise, the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming the patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which

there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent ..."

In Roberts v Wood, (30) defendant performed a thyroidectomy on the plaintiff, and, subsequently, the plaintiff experienced a hoarseness in her voice which interfered with her normal speech. This was plaintiff's second thyroidectomy, and she alleged, as one ground of complaint, that defendant had not sufficiently advised her as to the seriousness of the operation. In this connection, the court said: "There is no evidence that (the defendant) misrepresented the serious nature of the operation or failed to inform the patient of its attendant dangers. I do not mean to suggest that defendant should have told plaintiff of all the hazards involved, including the risk of injury to the recurrent laryngeal nerve. Doctors frequently tailor the extent of their preoperative warnings to the particular patient, and with this I can find no fault. Not only is much of the risk of a technical nature beyond the patient's understanding, but the anxiety, apprehension and fear generated by a full disclosure thereof may have a very detrimental effect on some patients. In this case the defendant told the patient, among other things that the operation would be similar to the one she had undergone in 1954. In view of the patient's emotional state and her concern over this operation as well as a gynecological operation to be performed at the same time, in addition to having previously experienced a thyroidectomy, I am of the opinion the

patient was properly advised of the seriousness of the operation."

Other facets of this are found in Natanson v Kline (31) which involved the use of a new medical procedure. In this case, defendant used "Cobalt 60" treatment on plaintiff. This was a new technique used in the treatment of cancer, and entails hazards not usually found in usual X-ray treatment. According to the facts shown, the defendant did not advise patient of additional risks, and the patient's chest was severely burned as a result of the treatment. The court said; "In our opinion the proper rule of law to determine whether a patient has given an intelligent consent to a proposed form of treatment by a physician compels disclosure by the physician in order to assure that an informed consent of the patient is obtained. The duty of the physician to disclose, however, is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment. So long as the disclosure is sufficient to assure an informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated only by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation .... We think upon all the facts and circumstances here presented Dr. Kline was obligated to make a reasonable disclosure to the appellant of the nature and probable consequences of the suggested or recommended cobalt irradiation treatment, and he was also obligated to make a reasonable disclosure of the dangers within his knowledge which were incident to, or possible in, the treatment he proposed to administer."

To point up the fact that law is not static, it is useful to refer to a 1918 Virginia case which involved X-ray therapy for exzema, as a result of which plaintiff was burned (32) . At the time of treatment, use of X-ray treatment for exzema was a new technique. Plaintiff claimed both negligence and failure of the defendant to warn of risks, which, plaintiff alleged, he would not knowingly have accepted. The court found for the plaintiff on the basis of negligent treatment. On the issue of informed consent, however, the court said: "The failure of a physician to warn a patient of the danger of the possible bad consequences of using a remedy is not per se an act of negligence."

In Mitchell v Robinson (33), plaintiff, suffering from severe emotional illness, although mentally competent, was advised by his physicians to undergo insulin shock therapy. Both plaintiff and his wife consented to the treatment. During the course of the treatment, the plaintiff suffered convulsions and compression fractures. In suing his psychiatrist, plaintiff stated he was not warned of risk of fractures. The physicians who treated plaintiff stated they had given this warning. The court said: "... Thus, the serious hazards being admitted, ... the doctors were under a duty to inform their patient of the hazards of the treatment, leaving to the patient the option of living with his illness or of taking the treatment and accepting its hazards..."

In some jurisdictions, the courts have indicated that the extent of disclosure required of a physician may depend on local custom, which must be established by expert medical testimony. This is brought out in two Delaware cases, DiFilippo v Preston (34) and Fisher v Wilmington General Hospital (35).

In DiFilippo v Preston, the court said: "Whether or not a physician or surgeon is under a duty to warn a patient of the possibility of a specific adverse result of a proposed treatment depends upon the circumstances of the particular case, and of the general practice with respect to such cases followed by the medical profession in the locality ... The custom of the medical profession to warn must be established by expert medical testimony ... In the case before us, all the expert medical testimony agreed that it was not the practice of surgeons in the Wilmington area to warn patients of the possibility of resultant injury to the recurrent laryngeal nerves from the thyroidectomy. This being the undisputed fact, it follows that there was no duty imposed on Dr. Preston to warn Mrs. DiFilippo of this specific possibility. Indeed, the general tenor of the medical testimony would seem to justify the inference that warning under the circumstances of this case would have been a departure from the usual custom or standard."

In Fischer v Wilmington General Hospital, the court said: "Considering the frequency of the use of transfusions, the nature and extent of the risk involved in comparison with the alternate risk, the possible detrimental effect of advising patients of the risk and the general practice in the local medical profession not to so advise patients, the court feels impelled to conclude that the defendant did not have a legal duty to plaintiff to advise her in advance that hepatitis might be communicated."

5. Scope of Consent. A physician may not, in the absence of exceptional or emergency circumstances, perform medical procedures different or more extensive than those consented to by the patient. (36) This rule is related to the rule concerning the "informed consent". Nonetheless, it is desirable, from the standpoint of the patient as well as the physician, that the form of

consent be stated in the broadest terms practicable, in order that it will be effective as covering unforeseen emergencies as to which, during the treatment, the physician might feel it is imperative to proceed without obtaining a further consent. (21) The typical situation referred to could arise during surgery, while the patient is under anesthesia. There is a number of cases which illustrate this problem.

In Nolan v Kechijian, (37) the patient consented to an operation "to build up the ligaments" that held her spleen in place. The surgeon removed the spleen, however. In holding that the matter should be retried, and that the judgment for the defendant should be reversed, the court said: "The extent of the consent ordinarily varies in each case. In consenting to an operation to relieve a given condition, an adult patient of sound mind is entitled to rely on the representations of a surgeon and in accordance with such representations to limit his consent to an operation reasonably appropriate to relieve him of his condition. Although a surgeon must necessarily be allowed reasonable latitude in performing the operation within the scope of the patient's consent, we know of no rule or principle of law which extends to him free license to operate at will. In the absence of exceptional circumstances, an operation in excess of consent ... constitutes a technical assault and battery for which he is liable in an action ..."

In Mohr v Williams (38), plaintiff consented to an operation on his right ear. While the patient was under anesthesia, the defendant found that the left ear was in a more serious condition and in greater need of an operation. Therefore, he operated on the left ear. In holding for the plaintiff, the court said, however, "... if, in the course of an operation to which the patient consented, the physician should discover conditions not anticipated

before the operation commenced, and which, if not corrected, would endanger the life or health of the patient, he would, though no express consent was obtained or given, be justified in extending the operation to remove and overcome them."

In Rogers v Lumberman's Mutual Casualty Co., (39), plaintiff recovered damages where authority for an appendectomy only was given, and the physician not only removed the appendix but also performed a complete hysterectomy (40).

The fact that a patient alleges that the defendant performed an operation without his consent does not automatically require a judgment against the defendant. In Bush v Stanton (41), a surgeon performed a hernia operation on plaintiff's right side. The plaintiff contended that the parties had agreed that defendant should operate on the hernia on plaintiff's left side, and that, therefore, the defendant had committed an assault and battery. Defendant, on the other hand, contended that prior to the operation, he had advised plaintiff that plaintiff's hernia on the right side should be operated on first, that plaintiff agreed, and that, therefore, he had operated with consent and there was no assault and battery. Despite the lack of written documentation, and based only on oral testimony, the jury rendered a verdict for the defendant.

## NOTES

1. 211 N.Y. 125, 105 N.E. 92, (1914)
2. Cited at footnote 1.
3. *Mohr v Williams*, 95 Minn. 261, 104 N.W. 12 (1905); *Schmeltz v Tracy*, 119 Conn. 492, 177 A. 520 (1935); *Rogers v Sells*, 178 Okla. 103, 61 P. 2d 1018 (1936); *Hively v Higgs*, 120 Ore. 588, 253 P. 363 (1927); *Throne v Wandell*, 176 Wis. 97, 186 N.W. 146 (1922).
4. *Birnbaum v Siegler*, 273 App. Div. 817, 76 N.Y.S. 2d 173 (1948).
5. *Physicians' and Dentists' Bureau v Dray*, 8 Wash. 2d 38, 111 P. 2d 568 (1941); *Maercklein v Smith*, 129 Colo. 72, 266 P. 2d 1095 (1954). See, also, *Woods v Brumlop*, 377 P. 2d 520 (1962).
6. See Chapter VII.
7. *Zotorell v Repps*, 187 Mich. 319, 153 N.W. 692 (1915); *Perry v Hodgson*, 168 Ga. 678, 148 S.E. 569 (1929).
8. *Mohr v Williams*, cited at footnote 3.
9. Cited at footnote 3.
10. 203 Ala. 272, 82 So. 522 (1919).
11. *Dicenzo v Berg*, 240 Pa. 305, 16 A. 2d 15 (1940); *Rogers v Sells*, cited at footnote 3.
12. *Gamage v Peal*, 217 F. Supp. 384 (1962).
13. Army Regulations 40-3.
14. *State v Housekeeper*, 70 Md. 162, 16 A. 382 (1889).
15. *Hershey v Peake*, 115 Kan. 562, 223 P. 1113 (1924), where a dentist pulled the wrong tooth.
16. In *Rogers v Lumberman's Mutual Casualty Co.*, 119 So. 649 (1960), the court found the following consent to be "so ambiguous as to be almost completely worthless": "I hereby authorize the Physician or Physicians in charge to administer such treatment and the surgeon to have administered such anesthetics as found necessary to perform this operation which is advisable in the treatment of this patient."
17. *Jacobsen v Massachusetts*, 197 U.S. 11 (1905).
18. *Buck v Bell*, 274 U.S. 200 (1927). In *Davis v Walton*, 74 Utah 80, 276 P. 921 (1929) the court said that a statute providing for sterilization of institutionalized mental defectives was not unconstitutional either as

imposing "cruel and unusual punishment" or as denying "equal protection of the laws."

19. Rogers v Sells, cited at footnote 3; Tabor v Scobee, 254 S.W. 2d 474 (1952); Moss v Rishwirth, 222 S.W. 225 (1920). In ~~both~~ of these cases, physicians were held liable for procedures performed on infants without the consent of their parents, there having been no emergencies. In the Moss case, moreover, consent of a sister who had custody of an 11 year old child was considered insufficient where consent of parents could have been obtained. In Jackovach v Yocum, 212 Iowa 914, 237 N.W. 444 (1931), amputation of the arm of a 17 year old child without the consent of the parents was held proper because of an emergency condition.

20. E.g., blood transfusions. Santos v Goldstein, 227 N.Y.S. 2d 450 (1962); Hoener v Bertinato, 171 A. 2d 140 (1962); State v Perricone, 181 A. 2d 751 (1962); In re Clark, 185 N.E. 2d 148 (1962); As a sidelight, see, also, Craig v Maryland, 220 Md 590, 155 A. 2d 684 (1959).

21. Paragraph 48, Army Regulations 600-20.

22. Schloendorff v Society of New York Hospital, cited at footnote 1; Diczno v Berg, cited at footnote 11; Jacovach v Yocum, cited at footnote 19; Franklyn v Peabody, 249 Mich. 363, 228 N.W. 681 (1930).

23. Lacey v Laird, 166 Ohio St. 12, 139 N.E. 2d 25 (1956).

24. Yackovach v Yocum, cited at footnote 19.

25. Moss v Rishworth, cited at footnote 19, ~~But~~ see, Bakker v Welsh, 144 Mich. 632, 108 N.W. 94 (1906).

26. See footnote 20.

27. Cited at footnote 14.

28. 377 P. 2d 520 (1962).

29. 154 C.A. 2d 56, 317 P. 2d 170 (1957).

30. 206 F. Supp. 579 (1962).

31. 186 Kan. 393, 350 P. 2d 1093 (1960).

32. Hunter v Burroughs, 123 Va. 112, 96 S.E. 360 (1918).

33. 334 S.W. 2d 11 (1960).

34. 173 A. 2d 333 (1961).

35. 51 Del. 554, 149 A. 2d 749 (1959).

36. Throne v Wandell, cited at footnote 1, where a dentist extracted six teeth although he had only been authorized to X-ray them.

37. 75 R.I. 165, 64 A. 2d 866 (1949).

38. Cited at footnote 3. Accord, Brennan v Parsonnet, 84 N.J.L. 20, 83 A. 948 (1912) where the court follows the "harsh" rule of Mohr v Williams, but points out the possibility of exceptions because of the widespread use of anesthesia.

39. Cited at footnote 16. The court said that a consent must be obtained except in "emergency requiring immediate action for the preservation of the life or health of the patient under circumstances in which it is impossible to obtain the patient's consent or the consent of anyone authorized to assume such responsibility. The general rule prohibiting the performance of an operation without the consent of the patient extends to the performance of operations different in nature from that for which consent was given, and to operations involving risks and results not contemplated." In Church v Adler, 350 Ill. App. 471, 113 N.E. 2d 327 (1953), the surgeon removed the patient's appendix without consent during an authorized hysterectomy.

40. Suppose the situation is reversed, and a surgeon finds an inflamed appendix, while performing an authorized hysterectomy. The failure of the surgeon to remove the appendix might be a basis for a malpractice suit.

41. 143 So. 2d 621 (1962).

## Chapter VII

### MISCELLANEOUS PROBLEMS

1. Introduction. In previous chapters, we have discussed problems which could lead to liability of the government for damages for malpractice under the Federal Tort Claims Act. It has been pointed out that such liability would be based upon negligence in rendering medical care, and that, as regards patients, the government may not be liable for damages for assault and battery, false imprisonment, libel and slander and the like.

These latter torts may, however, involve questions of individual liability of personnel of the Army Medical Service. Although they have not been important as sources of liability of personnel of the government in the past, they merit mention. Nevertheless, they will be discussed broadly, and in summary.

2. Assault and Battery. This subject has been discussed in the previous chapter, under the heading "Consent to Medical Procedures." As an added note, however, it is pointed out that a claim can be made against a physician alleging that he had struck or beat<sup>ed</sup> a patient, without the consent of the patient, while treating the patient. This is an unlikely occurrence, but, it could happen, or, at least, a patient could claim that it had happened.

3. False Imprisonment. This tort relates to every person's basic right to freedom of movement. An unauthorized act by a physician to impair or abrogate this right could lay a foundation for a suit for damages for false imprisonment. As examples, a suit based upon false imprisonment could arise out of a charge that a physician had wrongfully ordered a psychotic patient to be confined in a military hospital, or there could be an accusation that a patient had not been permitted to leave a hospital because she had not paid required charges.

It is, however, defensible for a physician to restrain a patient without the patient's consent, in an emergency or, if restraint is authorized by a court which has jurisdiction to issue a proper order.

4. Libel and Slander. Libel and slander are aspects of the tort known as "defamation". Defamation consists of a false communication, oral or written, which injures a person's good name or reputation, and holds him up to contempt or ridicule in the community. Slander is oral defamation, and libel is defamation by the written or printed word, by photographs or other visual means.

For a libel or slander to be actionable, it must be communicated or "published" by the physician to a third person without the consent of the patient, and without the protection of "privilege". If communication is made by the patient himself, or is accidentally seen or overheard by a person other than the patient, there is no publication by the physician.

An example of defamation by a physician would be one where a physician falsely tells a third person that a patient has a loathsome disease. Other examples, from cases not involving physicians are as follows:

In Buck v. Savage (1), a statement made by a defendant that plaintiff was "queer" on another man was actionable, because it imputed the commission of the crime of sodomy.

In MacRae v. Afro-American Co. (2), an action was sustained when a newspaper stated that the death of plaintiff's daughter had resulted from gas poisoning because the deceased was despondent over poor school grades and had been told not to come home unless her grades improved.

"Privilege" can often protect a physician from liability for defamation. Privilege may be either "qualified" or "absolute". The absolute privilege protects the physician when he makes a report required by statute or regulations, such as a report that a patient has a loathsome disease, or where a physician testifies erroneously in court as to a patient's mental condition (3).

The qualified privilege exists when a statement, although false, is made in good faith to a person who has a legitimate interest in the matter, such as a prospective employer who has sent a job applicant to a physician for a pre-employment physical examination. It should be noted that the privilege does not exist if the statement is made maliciously (4), or if the defendant has no reasonable grounds for believing the false statement to be true (5).

5. The Right of Privacy. This right is based on the right of a person to be let alone. Although truth may be a defense in an action for defamation, it is no defense in this action (6). Nor, is it a defense to show that the invasion of the right of privacy was done without malice (7). The tort of invasion of the right of privacy consists of:

a. Communicating information about a patient which, although true, is offensive; or

b. Publishing information about a patient for commercial purposes; or

c. Permitting an intrusion on the patient under embarrassing circumstances.

Under the first category, is the situation where "before" and "after" photos of a patient are published without his permission (8). Of course, if a story is newsworthy, it may be published for news purposes, but, in this connection, the type of publication would be a criterion (9).

The second category involves one in which the patient is listed in a paid advertisement as a satisfied user of a drug (10).

The third category could portray the situation where, in the course of an operation on a woman, unauthorized male observers are permitted to attend by the physician (11).

6. Fraud and Deceit. This is a tort which, in the physician-patient relationship, would consist of a fraudulent concealment by the physician of his patient's condition. This type of situation is indicated in Moses v Miller (12).

In that case, plaintiff went to the defendant physician with gall bladder trouble and the defendant advised removal of the gall bladder. The defendant subsequently performed an operation and stated that he had removed both the gall bladder and the appendix. Subsequently, the defendant again went to the defendant complaining about pain in her side, but the defendant said it was not her gall bladder hurting her, but her tonsils. Thereupon, he removed the tonsils. When the plaintiff continued to complain about her pain, the defendant wrote her a letter, in which he stated in part: "I have your letter of today and can assure you that you have nothing serious inside your abdomen. Your Gall Bladder has been removed and your appendix has been removed." Subsequent letters reiterated these allegations. Three years later the plaintiff underwent another operation for the removal of her gall bladder. In a suit for damages resulting from defendant's alleged fraud, the court stated there was sufficient evidence of fraud to justify submitting the case to a jury for decision.

In Kantrowitz v Candeleris (13), the court implied that an action for fraud would lie against a physician who guaranteed a result that he knew he could not possibly achieve.

## NOTES

1. 323 S.W. 2d 363 (1959).
2. 174 F. Supp. 184 (1959).
3. Jarman v Offutt, 239 N.C. 468, 80 S.E. 2d 248 (1954).
4. Buck v Savage, 323 S.W. 2d 363 (1959).
5. MacLeod v Tribune Publishing Co., 52 Cal. 2d 536, 343 P. 2d 36 (1959).
6. Pavesick v New England Life Insurance Co., 122 Ga. 190, 50 S.E. 68 (1905).
7. Meetze v Associated Press, 230 S.C. 330, 95 S.E. 2d 606 (1956).
8. Griffin v Medical Society of New York, 11 N.Y.S. 2d 109 (1939).
9. Sellers v Henry, 329 S.W. 2d 214 (1959); Barber v Time, 348 Mo. 1199, 159 S.W. 2d 291 ~~(1942)~~ (1947).
10. Fairfield v American Photocopy, 138 Cal. App. 2d 82, 239 P. 2d 194 (1955).
11. DeMay v Roberts, 46 Mich. 160, 9 N.W. 146 (1881); Carr v Shifflette, 82 F. 2d 874 (1936).
12. 216 P. 2d 979 (1950).
13. 163 N.Y.S. 2d 297 (1957).

A P P E N D I X E S

## APPENDIX A

### SOME LEGAL ASPECTS OF MILITARY PREVENTIVE MEDICINE

The field of military preventive medicine reaches into almost every corner of society. Preventive medicine officers are interested not only in preventing disease as such; they also may be involved in such things as the medical aspects of running an office or a factory, safety management of nuclear reactors, toxicity testing of products contracted for by the Government, and the prevention of accidents. All of these things may bring them into contact with the law.

A basic legal question may arise out of the fact that soldiers must be immunized against diseases. If a soldier has religious scruples about medical treatment, he may be given inoculations even if force has to be used. (1) In peace time, this presents no real problem. In those isolated cases where the question has arisen, in peace time, the recalcitrants have been eliminated from the Army by board action. A substantial problem may arise, however, when there is a step-up of the draft. Then, as has been found in the past, there could be an increased number of soldiers with religious scruples about being inoculated, and the regulations must be enforced to close an easy escape route from the Army.

When dealing with the dependents of military personnel, there is a different problem. Inoculations may not be administered to dependents without their consent. (2) In one instance, a dependent, who wanted to go overseas to join her husband, refused to take the required inoculations because of her religious beliefs. As some of these were required for international travel, she was advised that she would either take the shots or remain in the United States.

Some other aspects of military preventive medicine raise questions of international law that may be initially overlooked by medical officers. To illustrate: It can be expected that, in future wars, our troops will be exposed to diseases not found in the United States. Thus, in order for preventive medicine officers to do something about these diseases, they must arrange for students and researchers to be sent to foreign countries. Although each country will raise different problems, (3) some of the general problems presented would be:

1. What kind of an agreement do we have or do we need with the foreign country? Is it a treaty, an exchange of notes, a telephone conversation or just the result of a visit from an ambassador?
2. What will be the tax status of our researchers or students in the foreign country? Will they be subject to foreign taxes? May they bring household goods in or out without paying duty? Do they have to obtain local licenses for their automobiles? May they take their wives and children?
3. Who has criminal jurisdiction over our people if they are accused of crimes? Do they have diplomatic immunity?
4. What happens if our military physicians are sued for "malpractice". Or suppose, while driving their cars, they run into a native? Do the local courts have jurisdiction?

The Buy-American Act, (4) which is calculated to help American industry, can also have an impact on preventive medicine. For example, The Surgeon General of the Army recently received a request to grant an exception to the Buy-American Act so that one of our Army hospitals could buy a preserved human head in Vienna. The head was to be used to facilitate the study of histopathology of the ear and temporal bone. Justification for the exception was based on the fact that the item could only be purchased outside the United

States because three local commercial sources had offered to supply skulls only.

Much of the work to be done in preventive medicine cannot be done without using animals or humans for experiments. Now that work in defenses against biological warfare and radiation hazards is being accelerated, the use of animals and humans for experimentation has become more and more important.

As far as experiments on animals and humans are concerned, legislatures have taken greater steps to protect animals than humans. Apparently there are no laws that prevent experiments on humans if they volunteer and consent. Some states, however, have passed laws to protect animals, and Congress generally has before it for consideration several laws to regulate the treatment of animals used either in experiments by the Federal government or by those holding government contracts or government research grants. None of these has been enacted as yet.

Although there are no laws to regulate experimentation on humans, human experimentation is restrained by a series of rules and ethical considerations that are just as strong as laws. The basic rules are the so-called Nuremberg rules, which grew out of the war crimes trials held in Nuremberg after World War II. They have been adopted almost universally, and are one of the bases for military regulations which spell out the limitations and caveats to be applied to research which involves experiments on humans. (5)

In other fields of preventive medicine, actions may have to be taken which might infringe on the rights of owners of private property. It is useful to consider some of these.

One of these aspects arises out of the fact that military commanders are responsible for the health of their troops, and are authorized to declare private establishments and areas off-limits to troops in order to safeguard their health. Preventive medicine officers are relied on, in most instances, to make necessary inspections of premises, and recommendations. In the case of a restaurant, for example, a problem may arise if the proprietor should refuse to permit the Army representative to inspect. He might claim that Army inspection is unwarranted because his restaurant meets the standards of local government officials who have given him a health certificate. Of course, a proprietor's refusal might suggest that the place is actually unhealthful and should be placed off-limits, but the next step by the local commander would be guided by local command policy. A deciding factor in such a case could be the discovery that soldiers who have eaten at the restaurant are coming to sick call with stomach disorders.

Putting places off-limits requires the exercise of discretion and the practice of good public relations. One aspect of this is the question whether the Army should insist that restaurant owners, for example, maintain higher standards than are required by local laws or ordinances.

Another problem might arise if soldiers should contract venereal disease, and then disclose that their contacts were "pick-ups" at a local bar and grill where the eating and drinking facilities had passed Army inspection. The question could then be presented whether the place should be placed off-limits to cut down association with women who frequent it.

It is pertinent to note two other aspects of work in preventive medicine that may involve property rights of others: Spraying and sewage disposal.

The use of lethal sprays to kill germs and mosquitoes creates a number of problems both legal and, for want of a better word, social.

Such a problem is presented when spraying is necessary to protect a camp area from mosquitoes. Spraying the camp itself presents no real problems, but a problem may arise if, to get better protection, it should be necessary to spray an area surrounding or adjoining the camp.

In this connection, when spraying the camp area, how does one keep the spray from going onto private property, possibly injuring people, plants or animals? Or, if it is necessary to spray outside the camp, how does one get the consent of the private property owners both to travel on and spray on their property? Actually, obtaining rights concerning private property is usually handled by military engineers through lawyers, but sometimes even they meet obstacles. Thus, they occasionally must overcome allegations that spraying would kill the food birds eat so that the birds would starve.

Sewage disposal also may raise questions of law. For example, if sewage or garbage from a camp is to be disposed of by improper incineration, a question could arise by reason of noxious fumes covering the countryside. Or, if it should be proposed to empty raw sewage into a stream, questions might arise out of the fact that the water would be polluted both for drinking or as it might affect fish. These questions would be particularly important to downstream riparian owners -- that is, people who own land on the edges of the streams, and could lead to claims under the Federal Tort Claims Act. (6)

From the matters just discussed, it might appear that the practice of preventive medicine is constantly in conflict with the law. But, there are other aspects -- growing more and more important -- where the preventive medicine officer works with the law and the lawyer.

For example, there is a Federal statute which requires the military to aid and observe the enforcement of quarantine laws. (7)

Another illustration of working with the law is one that involves testing items purchased under Government contract. Assuming, for example, that the Government has contracted to buy a new type of paint, preventive medicine officers may be asked to run toxicity tests on the paint to determine whether it conforms to the terms of the contract. In fact, <sup>earlier</sup> toxicity tests by preventive medicine officers on other paints may very well have laid the foundation for drawing up the specifications for the paint thus being bought and tested.

Still another illustration involves nuclear reactors. Nuclear reactors must be built and operating <sup>ed</sup> in such a way that they will not present radiation hazards either to the people working in them or to the people living near them. Aside from anything else, radiation hazards, if not controlled, can result in law suits. Thus, preventive medicine personnel have the job of inspecting reactors in order to insure that they are maintained safe from radiation hazards. By assisting in this way, preventive medicine personnel help to comply with the law.

The involvement of industrial preventive medicine with the law includes studies of accidents and accident prevention, because accidents create legal rights and liabilities. These involve, not merely suits for damages, but also questions of hospitalization and insurance and retirement benefits, among other things. Thus, the preventive medicine officer is interested in learning, among other things, why people have accidents, why some types of accidents happen more frequently than others, what injuries are most apt to occur from using certain types of equipment in certain ways, and what changes in working hours, conditions or equipment should be made to cut down on accidents.

## NOTES

1. Paragraph 48, Army Regulations 600-20.
2. See Chapter VI.
3. Depending on the treaty, or other arrangements.
4. 41 U.S.C. 10a - 10d.
5. Army Regulations 70-25.
6. See Chapter III.
7. 42 U.S.C. 268

## APPENDIX B

### ARMY MEDICAL BOARDS

When a member of the Army is in an Army hospital, the matter of his disposition is basically a matter for decision by the hospital commander. In some cases, his decision may be based solely on the recommendations of the treating or attending physician. In other cases, his decision will be based on the evaluation and findings of a medical board.

As a general rule, the hospital commander has the option to make his determination on the recommendation of the attending physician (1) or to refer the case to a medical board. In some instances, however, Army Regulations negate this option, and require referral of cases to medical boards.

The commanders of all Army medical treatment facilities are authorized to appoint medical boards and review their proceedings. (2)

Medical boards are composed of three or more Medical Corps officers, one of whom must be a senior Medical Corps officer with detailed knowledge of directives pertaining to standards of medical fitness and unfitness, disposition of patients and disability processing. The other members must have at least a familiarity with these matters. If a case to be considered involves a psychiatric condition, a psychiatrist will be appointed to the board if it is feasible, and, if the board is to consider conditions which normally fall within the purview of the Dental Corps, a dental officer will be included. Civilian employees who are doctors of medicine, and contract surgeons may be detailed as members of a board, and a Medical Service Corps officer may be appointed as recorder without vote. Members of the board are not, ordinarily, subject to challenge.

A hospital commander will, of his own volition, usually refer a case to a medical board when there are controversial or problematical aspects concerning the probable disposition of the patient, the permanence of his disabilities, and the stability of his conditions.

In addition, pursuant to paragraph 42, Army Regulations 40-3, the following active duty Army personnel require consideration by a medical board:

1. Patients who are to return to a duty status after having been hospitalized over six months, to insure that the individual has correct physical profile, assignment limitations, and medical follow-up instructions, as appropriate.
2. Patients who have a doubtful prognosis, medical condition or physical defects that are usually progressive in nature, or whose situations are such that claims against the Government may be expected. (3)
3. Patients whose medical fitness or return to duty is problematical or controversial.
4. Patients who request consideration for continuance on active duty as outlined in Army Regulations 616-41.
5. Patients whose cases involve the possibility of mental incompetency.
6. Individuals scheduled for separation under AR 635-208 and AR 635-209, when it appears that a mental illness, medical condition or physical defect may be the direct cause of unfitness or unsuitability.

In addition, other regulations require referral of cases to medical boards under the following conditions:

1. Where it is proposed to return a man to a full duty status from a status involving duty or assignment limitations. (4)

2. When it is proposed to return a man to a full duty status from a temporarily restricted duty status imposed as the result of medical board recommendations. (5)

3. When it is proposed to recommend a patient for trial duty or duty with permanent assignment limitations. (6)

4. When a patient who does not meet retention medical fitness standards elects separation for a condition existing prior to service. (7)

5. When a patient who was erroneously enlisted meets retention medical fitness standards but did not meet procurement medical fitness standards, if he either consents to retention or requests separation. (8)

6. When a patient (except a general officer) desires continuance on active duty under Army Regulations 616-41, although he does not meet medical fitness retention standards. (9)

7. When a military patient has physical defects or medical conditions which indicate that a change of duty or station is warranted. (10)

Medical boards operate informally, and the procedures specifically spelled out for medical boards in Army Regulations 40-3 supersede conflicting provisions of other Army Regulations.

When a medical board meets, its members discuss and evaluate the patient's case, and, as appropriate, review his clinical, health and other records. Medical witnesses on the hospital staff may be called before the board, and, when a patient's condition permits, he will be given the opportunity to appear

in person and present his views relative to his proposed disposition. Each potential physical disability separatee, with minor exceptions, (11) is informed that in the event he is determined to be medically unfit for further active service, his case must be referred to a physical evaluation board with a view to disability separation.

In connection with medical board proceedings, the hospital commander may furnish the patient with a copy of his medical records. In view of the fact, however, that medical board proceedings are not adversary proceedings, the board has discretion whether to permit a patient to be represented by counsel (military or civilian) or to call witnesses on his behalf. The board is required to insure that all of the individual's medical and physical defects are determined and recorded. In cases of patients recommended for duty, the physical profile and appropriate duty assignment limitations or restrictions should be established.

Medical fitness or unfitness for further duty, regardless of motivation, is determined by a medical board on the basis of the medical fitness standards and guidance contained in Chapter III, Army Regulations 40-501. In forwarding its evaluation to the hospital commander in any case, a medical board does not have the authority to recommend disability ratings, or to express conclusions or recommendations regarding percentages or disability, as this is the prerogative of a physical evaluation board.

A medical board may recommend one of the following types of disposition of a patient:

1. Return to duty.
2. Retention under medical jurisdiction for later reevaluation.

3. Transfer to another hospital.
4. Referral to a Physical Evaluation Board.
5. Separation -- not for disability.
6. Separation for a disability which existed prior to entry on service.

A patient who disagrees with the findings or recommendations of a medical board will be given an opportunity to submit pertinent statements or evidence to the commander who appointed the board for his consideration. Statements or evidence so submitted become an integral part of the board proceedings.

The commander who appointed the board may approve or disapprove its findings and recommendations. If he approves, the recommended disposition is effected at the earliest practicable date. If the commander does not concur with the board's findings or recommendations, he must return the proceedings for further consideration. If he still does not approve the findings after reconsideration, the proceedings of the board are referred, with his recommendations, to The Surgeon General, for determination.

When the recommendation of a medical board that the member appear before a Physical Evaluation Board is approved, the member is informed in writing that, "The Medical Board's recommendation that you be found medically unfit for military service and processed for disability separation or retirement has been reviewed and approved by the medical treatment commander. It is emphasized, however, that this is a recommendation only and is subject to further consideration by a physical evaluation board and physical disability reviewing agencies at Headquarters, Department of the Army. In order to acquaint you with the steps of processing which are ahead of you, you are herewith furnished a copy of Department of the Army Pamphlet 21-48, (Disability Separation)." (12)

## NOTES

1. Unless referral to a medical board is mandatory, disposition of a patient by a hospital commander will normally be based on the recommendations of the treating or examining physician in those cases where a patient is to be returned to duty without any permanent revision in his profile, or if he is to be transferred to another hospital prior to final disposition, or if his condition is non-controversial. If, on the basis of such a recommendation, a commander should decide to refer a case to a physical evaluation board, the patient's attending medical officer will be required to record and summarize his findings in the same manner that is required for the proceedings of a medical board, using the same forms.
2. A commander who himself requires referral to a medical board will be referred to one not under his jurisdiction. Moreover, a Medical Corps officer who requires referral to a medical board will be ordered to appear before a board that is provided by a facility other than the one to which he is assigned for duty.
3. In these cases, medical board action is intended to insure the adequate documentation of the nature, extent and cause of all the medical conditions or physical defects in question.
4. Paragraph 54a, Army Regulations 40-3.
5. Paragraph 54b, Army Regulations 40-3.
6. Paragraphs 54c and 54d, Army Regulations 40-3.
7. Paragraph 54e(2), Army Regulations 40-3. If a patient does not elect separation, he may be referred to a medical board under some circumstances. Paragraph 54g, Army Regulations 40-3.

8. Paragraph 54e(3)(c), Army Regulations 40-3.
9. Paragraph 62, Army Regulations 40-3.
10. Paragraph 67, Army Regulations 40-3.
11. See Paragraph 51, Army Regulations 40-3.
12. A similar notice is furnished when a case is referred to a physical evaluation board without intermediate medical board action.

## APPENDIX C

### INCOMPATIBLE BLOOD TRANSFUSIONS

1. Introduction. Every transfusion of whole blood into a human being carries with it the possibility that it may cause him injury or death. Such a result may follow the transmission of infection that is present in the donor of the transfused blood, (1) or it may follow the transmission of infection by contaminant material contained on improperly sterilized syringes or needles. A transfusion also may cause injury or death if the transfused blood is incompatible with the blood of the recipient patient. (2).

There are interesting legal ramifications in each of the possibilities mentioned, but this <sup>Appendix</sup> ~~article~~ will be limited to a consideration of those aspects of law which are involved in transfusions with incompatible blood.

2. Blood Groups. (3) Blood is a fluid which carries three formed elements (solid or semisolid particles) known as red cells, white cells and platelets. (4) Red cells perform the function of carrying oxygen to the tissues, and are those <sup>Appendix</sup> ~~with~~ which this ~~article~~ is concerned.

Red blood cells have certain properties which may vary from person to person. These properties fall into separate categories known as blood groups; they cause red cells to clump together when blood containing red cells with properties of a particular group is mixed with other blood that contains substances that are antagonistic to those properties. When a mixing of blood samples results in the clumping of red cells, the blood in the samples is said to be "incompatible." (5)

The ability to categorize blood samples according to the clumping properties of their blood groups is a significant factor in giving blood

transfusions, because a transfusion with incompatible blood is fraught with danger to the patient.

When incompatible blood is administered to a patient, the clumping of red cells which may result can limit the flow of oxygen-bearing blood through the veins and arteries to the tissues; in addition, large clumps may accumulate in the kidneys or elsewhere. Incompatibility of mixed bloods can also lead to destruction of the oxygen-bearing red cells. The end results of incompatible blood transfusions may be the death of the patient, or permanent damage to his brain, kidneys, or other portions of his body.

The administration of incompatible blood may evoke symptoms in a patient before much blood has been transfused. These symptoms include pain, anxiety, flushing of the face, chill, and an increase in the pulse rate and respiration. They may be followed by shock, nausea, coma, high temperatures and delirium.

In some cases, early appearance of these symptoms may serve as a warning to stop the transfusion; if the transfusion is stopped soon enough, the patient may suffer little or no harm. (6) In other cases, however, early symptoms may be masked if the patient is under anesthesia, or already in shock: in the absence of a warning from observable symptoms, a transfusion is apt to be continued to a stage where only permanent injury to the patient, or his death, may ensue.

A number of techniques <sup>has</sup> ~~have~~ been developed in order to group and cross-match blood samples for compatibility. Because there is a great number of possible combinations of blood groups, however, not all of these techniques can be employed in every case involving a transfusion. Some of the limitations on the use of techniques include the economics of the situation and the avail-

ability of personnel and equipment.

3. Negligence. Most actions for damages for injury or death resulting from transfusions with allegedly incompatible blood are brought on the theory of breach of warranty of fitness of the transfused blood for its intended use.

For example, in Dibblee v Dr. W.H. Gross Latter-Day Saints Hospital, (7) the administrator of an estate brought an action against the defendant hospital for damages for the death of a patient following a blood transfusion. It could not be shown that the transfused blood had been negligently grouped or mis-matched, so the action was based on the breach of an implied warranty that the blood was "fit for the use for which it was intended". In denying recovery on this theory, the court said that the "furnishing of blood by a hospital at the specific request of a patient or his doctor, and for a charge, is part of a service, not a sale in any connotational sense of those terms". In Goelz v J.K. & Susie L. Wadley Research Institute and Blood Bank, (8) the same rule was applied in an action for breach of warranty against a blood bank which had supplied blood to the hospital in which the patient had received a transfusion.

In the light of presently available scientific knowledge, there are certain minimum standards of care which must be observed in performing blood grouping or cross-matching tests prior to a transfusion. Procedures which are acceptable and customary in the local medical community will usually set the standards to be followed, (9) but even these standards could be deemed inadequate in a court of law. (10)

Whether or not a hospital has followed customary methods and procedures in grouping and cross-matching blood would be probative, and, in most cases,

conclusive on the question of due care, unless the standards are obviously too low. The plaintiff has the burden of showing that the hospital was negligent.

Expert testimony can be particularly important on the issue of causation, because even when acceptable standard tests are scrupulously followed, and admittedly compatible blood is transfused, a patient may still suffer a transfusion reaction (a) because of his unknown physiological peculiarities, or (b) because his blood and the transfused blood contain as yet unidentifiable incompatible blood groups for which there are no grouping and cross-matching tests.

This problem of proving causation appears to militate against invoking the doctrine of res ipsa loquitur in actions involving transfusions with allegedly mismatched blood, even when evidence shows that the blood was in fact mismatched: a person does not always suffer a transfusion reaction from a transfusion with incompatible blood, but he may suffer such a reaction for other reasons when an incompatible blood transfusion is given.

4. Decisions in Point. There are not many reported cases based on alleged negligent injury or death from transfusions with mismatched blood, and not all of these are solely concerned with claims alleging negligent injury or death from transfusions with mismatched blood, and not all of these are solely concerned with claims alleging negligence in performing or following proper laboratory standards and techniques in grouping and cross-matching. Some cases involve the administration of mislabeled blood, and some involve the administration of incompatible blood to a person who did not require a transfusion (11). It is not possible to predict the possibilities for all new types of cases.

a. Erroneous tests. In Berg v New York Society for the Relief of the Ruptured and Crippled, (12) a husband and his wife brought an action against

the defendant hospital to recover damages for injury caused by a laboratory technician's negligence. The wife had been hospitalized for rheumatoid arthritis; in connection with her treatment, she was to have received a transfusion of blood. Before the transfusion, a sample of Mrs. Berg's blood was taken, and the necessary testing was performed. The laboratory technician mistakenly reported, however, that Mrs. Berg's blood was group A-Rh positive, whereas, in fact, her blood was group A-Rh negative. On March 19, 1947, 500 c.c.'s of Rh positive blood were infused into Mrs. Berg. On March 26, 1947, while she was again being infused with Rh positive blood, she developed an unfavorable reaction after 100 c.c.'s had been administered, and the transfusion was stopped. She was discharged from the hospital on April 12, 1947 and, shortly thereafter, became pregnant. As a result of the incompatible blood transfusions she had received while in the hospital, Mrs. Berg was sensitized to a point where the fetus had no chance of surviving, and died before delivery. In finding for the plaintiff<sup>s</sup>, the court held that the hospital was liable for consequential damages because of the negligence of its laboratory technician.

In Redding v United States, (13) the evidence revealed that, during the course of a hysterectomy, plaintiff Mrs. Redding was initially transfused with incompatible blood. When she appeared to be having a transfusion reaction, the blood was rechecked, and she was then transfused with compatible blood. Although the second transfusion saved Mrs. Redding's life, she suffered permanent damage to her kidneys, and developed a condition of rheumatoid arthritis. The defendant admitted that an error had been made in cross-matching Mrs. Redding's blood, offered evidence to show that all proper procedures had been followed, and that, in some cases, an error can be made despite the use of due care. This argument was rejected by the court, which

rendered judgment for the plaintiffs. In its opinion, the court discussed the question whether res ipsa loquitur should be applied, but it is not clear that the doctrine, as such, was followed.

In National Homeopathic Hospital v Phillips, (14) the hospital was held liable in damages for the transfusion death of a patient when it was shown that a laboratory technician had erroneously tested and reported incompatible blood as being compatible.

In Joseph v W.H. Gross Latter-Day Saints Hospital, (15) the plaintiff father, individually and as guardian ad litem for his children, brought an action for damages for the death of the mother, alleging that the hospital had been negligent in administering incompatible blood during a transfusion. The facts indicated that on April 4, 1953, Mrs. Joseph was operated on for the removal of an ovarian cyst, and received transfusions of two pints of blood, one during the operation, and the other after having been returned to her room. During the second transfusion, she manifested symptoms of undue distress, and she began to perspire, and to shake as if chilling. Ten days later, Mrs. Joseph died in the hospital of a lower nephron nephrosis (inflammation of the kidney that prevents it from functioning) which appeared to have resulted from an incompatible blood transfusion. The claim of negligence was that the hospital had failed to exercise proper care in (a) grouping and matching the blood; (b) administering the transfusion; and/or (c) failing to stop giving the transfusion after an unfavorable reaction was or should have been noticed. The jury found for the defendant hospital. On appeal, the plaintiff asked the court to invoke the doctrine of res ipsa loquitur, but the court refused to do so. The court pointed out that the evidence showed that the hospital had taken all reasonable precautions to assure proper matching of blood before

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had negligently failed properly to determine Mrs. Gillen's blood group, that they had transfused her with incompatible blood, and that the onset of the nephrosis and her death were direct and proximate results of this negligence. Although the evidence, particularly the testimony of medical experts, was conflicting, the court found that Mrs. Gillen had not been transfused with incompatible blood, and that the onset of the nephrosis and her death were direct and proximate results of this negligence. Although the evidence, particularly the testimony of medical experts, was conflicting, the court found that Mrs. Gillen had not been transfused with incompatible blood, and that the nephrosis and death were not occasioned by her receipt of incompatible blood. In a footnote to its opinion, the Court of Appeals stated: "Hemorrhage loss of 1,000 c.c.'s of blood and a manual removal of retained (12-13 days) placenta resulted in utero-placental damage to the deceased. Medical testimony showed that lower nephron nephritis could be caused by 12 physiological conditions, three of which are,.. transfusion reaction ... shock, ~~LD~~<sup>LD</sup> and interplacental damage." The court refused to apply the doctrine of res ipsa loquitur as a conclusive presumption.

b. Mislabeled blood. In Parker v Port Huron Hospital, (17) the sample tube containing the patient's blood was mixed with two other tubes contain<sup>ing</sup> the blood of other patients. Although the sample in each tube was correctly grouped and cross-matched, the laboratory technician labeled the wrong sample as coming from the patient involved in the case. As a result the patient was transfused with incompatible blood, and died. The court held for the plaintiff, because it was shown that the technician had not followed acceptable procedures in labeling the samples.

In Mississippi Baptist Hospital v Holmes, (18) the laboratory technician correctly grouped the blood of two patients, but inadvertently switched identification labels. As a consequence, one of the patients was given blood of the wrong blood group, and died. The court found the hospital liable. In this case, the defense experts contended that even though the wrong blood had been given, it could not be stated with certainty that the transfusion had caused the death, as there had not been an autopsy. The court, holding that the plaintiff need not "prove to a moral certainty and beyond every other reasonable hypothesis the exact cause of the death complained of," said: "To illustrate that these experts in giving their testimony that something else could have happened had in mind reasonable possibilities as against the contention that the transfusion of the wrong type of blood had in fact caused her death as a reasonable probability, some of them testified that if one should see a person shot in the head with a pistol and then see the victim fall over and die instantly, an autopsy would still be necessary in order to determine the cause of death with a reasonable degree of certainty. This high degree of proof is not even required in a homicide case."

In Mazur v Lipshutz, (19) the facts showed that plaintiff's decedent, Israel Abrams, had entered the hospital on December 17th for an operation, and was placed in room 807. On the same day, another Israel Abrams entered the same hospital and was assigned to room 342. Following usual hospital practice, the anesthetist for the operation on the first Israel Abrams ordered two pints of blood to be made available in the operating room. During the course of the operation, the anesthetist sent for a bottle of blood, and noted that it bore the name "Israel Abrams", but the wrong room number. He called for the head blood bank technician, a hospital employee, who assured him

that the blood was correct for the Israel Abrams then on the operating table. Thereafter, a total of six pints of incompatible blood was administered, and the patient died. In individual actions against the surgeon and the anesthetist (the hospital had been given a release) the jury found both defendants free from negligence. The court denied a motion for a new trial as against the surgeon, pointing out that the surgeon had not had control of the employees of the hospital and, therefore, could not be charged with responsibility for their negligence.

c. Wrong patient transfused. Necolayff v Genessee Hospital (20) was a case where an interne and a nurse gave a transfusion of incompatible blood to a patient who did not require a transfusion. The transfusion had been intended for another patient on the same floor. The defendant hospital was held liable for negligent injury.

In Weiss v Rubin, (21) an action for damages was brought against the hospital, the anesthetist and the surgeon, when death occurred to a surgical patient who had received blood intended for another. A judgment against all three defendants was sustained on appeal. The facts, briefly, indicated that during the course of an operation upon the decedent, the surgeon was told by the anesthetist that he had the patient's blood ready. The anesthetist asked "Shall I give it?" and the surgeon responded in the affirmative. The circulating nurse had come into the operating room with a bottle of blood on which there was a slip with the name of another patient, previously operated, but not by the defendant surgeon, at which operation the circulating nurse and the anesthetist had also been present. The proof showed that although it was the duty of the surgeon to order blood, (22) he had neither ordered blood for this patient nor asked how it had gotten into the operating room.

5. Conclusion. The fact that there are few reported cases involving transfusions with incompatible blood may be interpreted as meaning that, in the great majority of cases involving transfusions, patients are transfused with compatible blood. The fact that errors can be made, however, suggests that hospitals and blood banks should make certain that their grouping and cross-matching procedures are adequate, and that they are strictly followed by competent personnel under proper supervision.

## NOTES

1. Perlmutter v Beth David Hospital, 308 N.Y. 100, 123 N.E. 2d 792 (1954); Fischer v Wilmington General Hospital, 51 Del. 554, 149 A. 2d 729 (1959); Giambozi v Peters, 127 Conn. 380, 16 A. 2d 833 (1940); Hoyt v Cornwall Hospital, 169 Misc. 361, 6 N.Y.S. 2d 1014 (1938).
2. This enumeration does not, of course, run the gamut of possibilities for misadventure to patients as a result of blood transfusions. It serves as a warning, however, that blood transfusions should not be administered indiscriminately.
3. This is a rudimentary explanation in non-technical terms. It is recognized that whenever scientific matters are translated into English for the layman, something may be lost in the translation.
4. Red cells and white cells are also known as red corpuscles and white corpuscles, respectively.
5. The clumping properties of red blood cells were originally categorized by four letter groups designated A, B, AB and O. Subsequently, additional blood groups were identified, and were given designations such as M-N, Rh-Mr, Kell, Lewis, Lutheran, Duffy and Kidd. All of these groups may be further divided into subgroups, and each red blood cell may contain the properties of one or more of these groups and subgroups. It is probable that there are subgroups of presently known groups that remain to be discovered. Blood groups are transmitted into genes according to Mendel's laws, so thousands of different combinations of groups are possible. Although, as a general rule, there may be incompatibility between two blood samples containing dissimilar blood groups, it has been found that in the A, B, AB and O groupings, group O blood may be given with relative safety to persons with blood of group A, B or AB. Thus O blood is known as "universal donor blood."
6. In Joseph v W.H. Groves Latter-Day Saints Hospital, 10 Utah 2d 94, 348 P. 2d 935 (1960), one of the allegations of plaintiff was that the defendant had failed to stop giving the transfusion after an unfavorable reaction was or should have been noticed.
7. 12 Utah 2d 241, 364 P. 2d 1085 (1961). To the same effect, see Perlmutter v Beth David Hospital, cited at Note 1 and Gile v Kennewick Public Hospital District, 48 Was. 774, 296 P. 2d 662 (1956).
8. 350 S.W. 2d 573 (1961). An exception to the requirement for pre-transfusion blood grouping and cross-matching may be found in an emergency situation where advance tests are not feasible. In such a case, transfusion of universal donor blood (note 5) to a patient who later suffers a transfusion reaction should not, in and of itself, be considered blameworthy.

9. See "Malpractice and the Federal Tort Claims Act," THE INSURANCE LAW JOURNAL, August 1963, p 457.

10. *Favorala v Aetna Casualty and Surety Company*, 144 So. 2d 544 (1962).

11. There is a type of case related to those individual transfusions with mismatched blood. This type indicts a failure to give an exchange transfusion to a newborn infant where there is an Rh factor incompatibility between the patients. See, *Price v Neyland*, 320 F. 2d 674 (1963).

12. 1 N.Y. 2d 499, 136 N.E. 2d 523 (1956). For a detailed statement of facts, see the lower court opinion in 136 N.Y.S. 2d 528 (1954). Compare this case with *Price v Neyland*, cited at footnote 11, and *Quinton v United States*, 203 F. Supp 332 (1961).

13. 196 F. Supp. 891 (1961).

14. 181 F. 2d 293 (1950).

15. Cited at footnote 6.

16. 281 F. 2d 425 (1960).

17. 361 Mich. 1, 105 N.W. 2d 1 (1960).

18. 214 Miss. 906, 55 So. 2d 142, 56 So. 2d 709 (1951).

19. 31 F.R.D. 123 (1962).

20. 270 App. Div. 648, 61 N.Y.S. 2d 832 (1946).

21. 11 App. Div 2d 818, 205 N.Y.S. 2d 274 (1960), *aff'd* 9 N.Y. 2d 230, 173 N.E. 2d 791 (1961).

22. Cf. *Mazur v Lipshutz*, cited at footnote 19, where the anesthetist had the duty to order blood.

APPENDIX D  
BLOOD ALCOHOL TESTS  
AND  
DRUNKEN DRIVERS

1. The Need for Blood Alcohol Tests. When a person imbibes alcoholic beverages, the alcohol enters the stomach and intestines where it is absorbed into the blood and then carried through the body to the tissues and the brain. Alcohol, on reaching the brain, eventually depresses the brain centers that are concerned with mental alertness, motor control and inhibitions. (1) The extent to which a person will be mentally or physically affected by alcohol, however, depends, in large part, upon the person himself (2), the amount imbibed, and the amount of alcohol absorbed into the blood and transported to the brain. Moreover, whether a person may be considered to be under the influence of liquor in a particular legal situation, and the degree, depends on the situation under scrutiny. For example, a person who has imbibed may be legally incapable of safely operating a motor vehicle, but, at the same time, may be legally capable of executing a valid will or contract. (3)

In State v Robinson, (4) the defendant was convicted of driving while under the influence of liquor, although he was not involved in any accident. On appeal, the appellant claimed that it was unjust to convict a motorist of driving while under the influence of liquor by requiring the state to prove only that the accused was under the influence of intoxicating liquor to a perceptible degree, while on the other hand, if a motorist is involved in an auto accident and injures someone, the plaintiff in a civil suit is required to show not only that the motorist was under the influence of intoxicating

liquor but also that the liquor had made him incapable of operating his vehicle as a reasonably prudent sober person should. The court rejected this distinction in the light of the applicable criminal statute, saying:

"This statute is designed, through the punishment of offenders, to deter persons from driving on the public highways when they have voluntarily allowed their physical coordination and mental faculties to become hampered and dulled by intoxicating liquor. The test whether a motorist is driving under the influence of intoxicating liquor is not his fitness or unfitness to drive an automobile but, rather, whether he has imbibed to an extent that his mental and physical condition is deleteriously affected. In this condition he increases the danger of accident that already inheres in the movement of automobiles in increasing numbers on our highways. In light of the enlarging number of automobiles using our highways, the expanding number of arrests for driving while under the influence of intoxicating liquor, and the increasing number of fatalities in automobile accidents involving drinking drivers, the courts should not, in the absence of compelling reasons, liberalize the law in favor of those accused of this offense. To give vitality to appellant's definition would place a needless hurdle in the path of the state, impeding its work to make the highways safer."

The courts will normally accept lay opinion testimony as to a person's state of intoxication when induced by alcoholic beverages, because alcoholic intoxication is a matter commonly experienced, and usually is not adequately conveyed to the court by a mere recitation of the facts observed by the witness. (5) Opinion evidence based on observation and experience may be subject to question, however, even if elicited from a police officer (6) or a physician (7) because, among other reasons, it may result from inadequate observation or may be improperly influenced by the subjective feelings of the witness. (8) Furthermore, things are not always what they seem: A person who has been subjected to trauma might appear to be under the influence of liquor although he has had nothing to drink, (9) whereas a person who is under the influence might be able to maintain an outward appearance of sobriety (10).

Early in the motor vehicle age, the fallibility of opinion evidence raised serious problems in motor vehicle situations, both civil and criminal, when proof of the sobriety or insobriety of motor vehicle operators was in issue. These problems were particularly oppressive in criminal prosecutions of alleged drunken drivers where it was necessary to prove guilt beyond a reasonable doubt. In order to prevent the acquittal of guilty drivers ( as well as to protect the innocent) and in order to be able to evaluate the negligence of alleged drunken drivers in civil cases, it soon was realized that scientifically accurate tests for drunkenness would be needed in the interest of promoting highway safety and justice. (11)

Several scientific tests have now been developed, but of these, the most accurate is the blood alcohol test. (12) This test permits the measurement of the alcoholic content/in the blood of a person, and, from these measurements, certain presumptions arise. (13) Basic presumptions recommended by the National Safety Council and the American Medical Association have generally been accepted by the courts and legislatures, and are as follows:

a. Although there is no established minimal figure at which there will be absolutely no effect from alcohol, persons with a concentration of alcohol of less than 0.05 of 1% by weight in blood or its equivalent in urine, saliva or breath should not be prosecuted for driving while under the influence of alcoholic liquor.

b. Between 0.05 and 0.15 of 1%, a liberal, wide zone, alcoholic influence is usually present, but courts of law are advised to consider in addition the behavior of the individual and the circumstances leading to his arrest in determining "under the influence".

c. At 0.15 of 1%, or above, there is definite evidence of "under the influence", since every individual with this concentration has lost, to a measurable extent, some of that clearness of intellect and self control that he would normally possess. This amount should, therefore, be accepted by the courts as prima facie evidence of alcoholic intoxication.

In 1960, it was recommended that the upper limit of 0.15 of 1% be lowered to ~~0~~.10 of 1%.

Although the mentioned presumptions were developed for use in connection with drunken driver cases, they may be of limited value in other types of cases provided it is understood that they are basically geared toward motor vehicle operation. As has previously been indicated, the fact that a blood alcohol test would indicate a person to be presumptively incapable of driving an automobile with safety would not also <sup>necessarily</sup> indicate that he is presumptively incapable of executing a valid will.

2. Reliability of Blood Alcohol Tests. The use of blood alcohol tests in drunken driver cases is now generally accepted by the courts and the legislatures, although not all states have enacted laws on the subject (14).

In any particular case, however, a court has discretion whether to accept or reject the test results, and expert testimony also may be required. In this connection, statutory inclusion of presumptive figures, such as those recommended by the National Safety Council and the American Medical Association, eliminates the need for expert testimony to interpret the presumptive meaning of figures obtained in a test. In State v Childress, (15) the court held that instructions based on statutory presumptions did not deprive the defendant of due process by presuming his guilt and relieving the state of proving such guilt beyond a reasonable doubt.

A good discussion of the subject of proof of the reliability of blood alcohol tests is found in City of Columbus v Marks, (16) which involved an appeal from a conviction in the Municipal Court of Columbus, on the charge of operating a vehicle under the influence of alcohol. The single assignment of error was the admission of expert testimony based on a blood test of the defendant. The opinion of the court is liberally quoted;

"After his arrest, the defendant was taken to the police station. With his consent, and at his request, he was given a blood test. This was taken in a small room used for this purpose at police headquarters. The arresting officer testified that he observed the specimen being taken. He did not recall the name of the person taking it but referred to him as an intern. The specimen was placed in a glass vial which was empty at the time. He did not recall where the vial had been kept. He stated that before inserting the needle the person taking the specimen cleansed the defendant's arm with alcohol or iodine or whatever disinfectant they use. After the taking of the specimen, he sealed and labeled it, took it to the laboratory and placed it in the refrigerator. He did not recall where the defendant was at the time the vial was sealed and labeled.

"The police chemist testified that the person on duty at that time, and whose name appeared on the specimen vial, was an extern by the name of Michael. He stated that as part of his duties, he, the chemist cleansed and sterilized the vials, that he took these to the room in a sealed bag, that he did not deliver them to any particular person, and that he did not know who had charge of the room. He had no knowledge with respect to the particular vial used for the defendant's specimen prior to receiving it for testing.

"The defendant objected to the admission of the expert testimony of the chemist with respect to the testing of the blood specimen and the test results. The grounds were (a) the specimen vial was not sealed in the presence of the defendant and (b) the identity of the person who took the specimen was not known.

"Whether the defendant was present at the time of the sealing and labeling goes to the weight of the evidence. It is not part of the foundation for its admission.

"The defendant relies primarily on the second ground of the objection. The person who took the specimen was never called as a witness by the prosecution. The defendant argues that he was denied the right to cross-examine that person as to the manner of taking the specimen, the condition of the equipment, his competency, etc. Counsel contend that this was a substitution of the officer's testimony for that of an essential witness and, therefore, a break in the chain of evidence."

"Defendant was not denied the right to cross-examine any witness presented. The witness here was never called, nor is there any break in the chain of evidence establishing the identification of the specimen tested. The basis of defendant's contention is a proposition that the person taking the specimen was essential to the admission of the expert testimony, and that we should hold him to be essential because to do otherwise is to deny the defendant an opportunity to cross-examine. As we understand it, the defendant is not arguing that this witness was essential in any sense of the proof of facts under evidence law, but that we should so hold as a matter of constitutional right in order to afford the defendant a fair means of meeting this scientific evidence. In this respect the argument is somewhat analogous to the exclusionary rule under which admissibility is denied to competent, relevant evidence which was illegally obtained. See *Mapp v. Ohio* (1961), 367 U.S. 643, 81 S.Ct 1684, 6 L. Ed 2d 1081.

"In our opinion the requirement that the prosecution lay a proper foundation for the admission of expert testimony on blood tests affords an adequate protection for the defendant's interest. There must, of course, be a foundation showing a complete chain of evidence establishing the identification of the specimen (17). However, the admissibility of data from scientific tests also requires reasonable proof of three other recognized aspects of foundation:

- (a) The test used must be legally acceptable. (18)
- (b) The particular apparatus used must be reliable.
- (c) The test must have been conducted and the apparatus used in a competent manner by a qualified person.

"An extensive review of some cases with respect to blood tests shows that most litigation concerns the identification of the specimen. The next most substantial group of authorities has dealt with the reliability of the test used. Considerably fewer cases deal with the apparatus used in testing or with the competency of the person making the test. There has been very little litigation with respect to the apparatus used, or the competency of the person, in the taking of the blood specimen itself.

"In most instances of the use of scientific data the sufficiency of the specimen as a specimen is obvious and not contested. However, the apparatus used to obtain a specimen and the manner of its use can be an integral part of the process. In such cases reasonable proof of the reliability of the specimen is just as essential to the foundation as is the reliability of the test itself, or the testing process.

"In blood tests the specimen can be unreliable. Factors in the obtaining of a specimen which can affect it include the sterilization of the sampling apparatus in alcohol, the use of an alcohol swab on the arm, the failure to obtain whole blood, etc. These factors may contaminate or otherwise make the specimen itself an unreliable basis for testing. See 39 Jour. Crim.L. & Criminology (1948-49), 225, 402, 411. See, also, Murphy

Admx., v New York State Thruway Authority (1960), 23 Misc. 2d 1078, 204 NY S 2d 953, where the court dealt with the competency and qualifications under New York law of the person taking the specimen. On the effect of an alcohol arm swab, see People v Ward (1958), 14 Misc 2d 518, 178 NYS 2d 708; People v Maxwell (1959), 18 Misc 2d 1004, 188 N.Y.S. 2d 692; People v Douglas (1959), 16 Misc. 2d 181, 183 N.Y.S. 2d 945; People v Modell (1956), 143 Cal. App. 2d 724, 300 P. 2d 204. Even though reliable when taken, a specimen can also become unreliable because not properly preserved or cared for. See 21 A.L.R. 2d 1216, 1229. That is not involved in this case. (19)

"In the present case there is a virtual absence of evidence as to the reliability of the particular apparatus used to obtain the specimen, and of evidence on the competency of the person who took it. However, the objection in the trial court was specific, and neither there nor in this court has defendant attacked the admission of the evidence in that regard. We, therefore, express no opinion on the evidentiary sufficiency of the foundation. In our opinion the right to require a proper foundation for the admission of the scientific data, if insisted upon, together with the right to attack it by presenting contra evidence, provides the opposing party with adequate opportunity to protect his interest.

"It may be that in order to lay a sufficient foundation, an attorney would as a practical matter find it convenient or even necessary to present the person who actually took the blood specimen. However, it is not necessary to call such a witness as a matter of law regardless of the sufficiency of the evidentiary foundation.

"The judgment of the Municipal Court will be, and hereby is, affirmed."

A corollary to the question of reliability of blood alcohol tests is the necessity for following procedures enunciated by statutes, when the statutes designate those individuals who are deemed qualified to make the tests. (20)

3. Consent to Blood Alcohol Tests. Blood alcohol tests and their use in court have generated a number of constitutional questions. The only constitutional aspect of present importance involves the requirement that, if blood tests are to be admissible in court, the suspect must consent to having his blood drawn for the purpose of using the test results in court. (21) This aspect involves due process and unlawful search and seizure; it is generally understood that the necessity for consent involves a question of battery rather than that of self incrimination. (22)

As an exception to the decisions requiring consent, the Supreme Court of the United States has held (23) in a decision that may presently be questionable, and which is not universally followed in the state courts, (24) that in the absence of a statute dealing with consent, when the suspect is unconscious, blood may be drawn and the test results may be used in court without the act being considered a battery or violating the subject's constitutional rights. (25) It has been held, however, in a case involving blood drawn from an unconscious motorist that, when statutory procedures for taking blood from a conscious subjects are not followed in the case of an unconscious subject who does not later consent to use of the results in court, the results could not be introduced in evidence. (26) In State v Tripp, (27) constitutional questions were avoided, because, after regaining consciousness, the defendant consented to the introduction of blood alcohol test evidence (28).

In order to assist authorities in obtaining consents to take blood and use test results in courts, a number of states have enacted "implied consent" statutes. The first of these was enacted in New York, in 1953, and presently provides (29) that, if a person is arrested on a charge of driving while intoxicated in the state and is asked to take a blood test, he may be required to choose whether or not to submit to a test to determine the alcoholic content of his blood. His operation of the vehicle upon the highways of the state is deemed to constitute a consent, not that the blood test be taken, but to being obligated to make a choice whether to take the test or to refuse to take the test. If the driver refuses to take the test, the statute provides that his operator's license shall be revoked. The law also provides that, to be effective, the blood test must be taken within two hours of arrest.

An interesting aspect of this statute was developed in Finocchairo v Kelly (30). In this case, a driver was arrested but, before deciding whether to take a blood test, he insisted on his right to call counsel. He was told, however, that he could not consult with a lawyer, before making his decision, even by telephone. He thereupon declined to submit to the test, and as a result, his motor vehicle operator's license was revoked. He was, however, acquitted on the criminal charge of driving while intoxicated. On appeal from the action revoking his license, the Court of Appeals upheld the revocation. Judge Van Voorhis, in a concurring opinion, pointed out that revocation was not a criminal action and that, therefore, due process had not been violated. On the other hand, he stated that the question of due process as regards the criminal charge was not before the Court of Appeals because the defendant had been acquitted.

Related to the matter of consent is the physician-patient privilege, which, in many jurisdictions, bars a physician from testifying as to matters learned in the course of treating a patient. It is considered, however, that the privilege does not exist unless there is actually a physician - patient relationship, and it certainly does not exist when the blood test is made by a physician at the request of state authorities (31). Thus, the physician may testify in court on this subject, and, in the Federal courts, the Federal Shopbook Rule allows the admission of hospital records of blood alcohol tests in a proper case, provided the trustworthiness of the records <sup>is</sup> ~~are~~ not successfully attacked. (32)

## NOTES

1. Contrary to popular belief, alcohol is not a stimulant. It appears to stimulate because, by depressing brain centers that control inhibitions, it "loosens up" the drinker and may lead him to do things he would not normally do when fully inhibited. As more and more alcohol reaches the brain, will-power is weakened, and judgment and motor control are diminished or lost.
2. Weight, rate of absorption of alcohol into the blood, strength of will-power and habituation may be factors in this regard.
3. People v Haeussler, 41 Cal. 2d 252, 260 P. 2d 8<sub>1</sub> (1953), cert. den. 347 U.S. 931 (1954).
4. 385 P. 2d 754 (1963).
5. Johnson v Vaughn, 370 S.W. 2d 591 (1963); United States v Ayers, 14 USCMA 336, 34 CMR 116 (1963); Jackson v Prestage, 132 S.E. 2d 501 (1963). In Jackson v Prestage, ~~132 S.E. 2d 501 (1963)~~ the Supreme Court of Appeals of Virginia affirmed the doctrine of earlier Virginia civil cases that the mere odor of alcohol on a person's breath is not sufficient proof of intoxication, and, if that is all that can be shown, the evidence is properly excluded from the jury.
6. City of Columbus v Samuels, 174 N.E. 2d 280 (1960). But, see, Graves v State, 370 S.W. 2d 806 (1963).
7. Thomas v Martin, 202 F. Supp 540 (1961). In many cases, the testimony of a psychiatrist is pertinent where intent, willfulness or premeditation is an element of the crime or a factor in determining its seriousness.
8. The fact that manifestations of drunkenness may really be manifestations of pathological conditions may make it difficult for a layman to determine whether a person is drunk.
9. See, Johnson v Borland, 317 Mich. 225, 26 N.W. 2d 755 (1947).
10. There are, of course, certain outward manifestations that may indicate intoxication, such as a flushed face, liquor on the breath, inability to coordinate movements, thickness of speech, stupor, coma, or change in the size of pupils. But, as indicated by Johnson v Borland, cited at footnote 4, even a physician may fail properly to evaluate the condition of a person he has seen for the first time.
11. State v Harold, 74 Ariz. 210, 246 P. 2d 178 (1952).
12. Blood alcohol tests must normally be given by a physician or skilled technician (State v Hart, 124 S.E. 2d 816 (1962) - hematologist), and this may limit their availability. Thus, chemical tests of the breath, by means of instruments such as the "breathometer", are gaining popularity because they can be given by trained laymen. Urine tests may also be used, Toms v

State, 239 P.812 (1952). Regarding the requirement that a physician administer blood alcohol tests, it is interesting to note that in *People v Stanton*, 33 Misc 2d 921, 228 NYS 2d 858 (1962), the court ruled that an intern associated with a municipal hospital was a "physician" within the meaning of New York's Vehicle and Traffic Law, and that a blood test based on blood drawn by the intern while on duty, at the request of a police officer, was properly admitted into evidence.

13. The most accurate test would be one by which the alcoholic content of the brain could be measured, but such a test would be impractical for live persons.

14. See *Robinson v Life and Casualty Ins. Co. of Tennessee*, 122 S.E. 2d 801 (1961). See, also, *Toms v State*, cited at footnote 12, for a discussion of the validity of chemical tests for alcohol.

15. 78 Ariz. 1, 274 P. 2d 333 (1954).

16. 194 N.E. 2d 791 (1963). See, also, *Erickson v North Dakota Workmen's Comp. Bureau*, 123 N.W. 2d 292 (1963) which involved a widow's claim for death benefits in North Dakota Workmen's Compensation proceedings. In this case, willful intoxication of the deceased was not proved as a bar to benefits.

17. But it has been held that the fluids themselves need not be available in court for examination by the defendant. *City of Columbus v Marks*, 194 N.E. 2d 901 (1963). On the matter of chain of custody, see, also, *Russell v Pitts*, 123 S.E. 2d 708 (1961); *People v McFarren*, 222 NYS 2d 828 (1961); *State v Augur*, 196 A. 2d 562 (1963); *Apodaca v Baca*, 385 P. 2d 963 (1963).

18. When a statute relating to blood tests of motorists does not set up standards by which the tests are to be made, "it is not only necessary to establish the standards for the test, but to further establish that they have been complied with and that they satisfy recognized scientific and medical standards." *People v McFarren*, cited at footnote 17.

19. In *State v Tripp*, 180 A. 2d 601 (1962), the defendant raised the question that the interval between the accident and the drawing of the blood was so long that it affected the validity of the blood sample for testing.

20. See *People v Stanton*, cited at footnote 12.

21. *Mapp v Ohio*, 367 U.S. 643, 81 S.Ct 1684 (1961) rehearing denied, 82 S.Ct 23 (1961). See, also, *Breithaupt v Abram*, 352 U.S. 432, 77 S. Ct. 408 (1957).

22. *State v Harold*, cited at footnote 11, *State v Alexander*, 7 NJ 585, 83 A. 2d 441, (1951).

23. *Breithaupt v Abram*, cited at footnote 21.

24. *State v Wolf*, 51 Del. 322, 164 A. 2d 865 (1960); *Label v Swincicki*, 354 Mich. 427, 93 N.W. 2d 281 (1958).

25. In *Ravellette v Smith*, 300 F. 2d 854 (1962) it was held that taking a blood sample from a decedent's body without the consent of his widow did not violate the widow's constitutional rights under the Indiana Constitution and that evidence as to blood alcohol in decedent's body was admissible in an action for his wrongful death. In *Robinson v Life & Casualty Ins. Co of Tennessee*, cited at note 14, the court stated that, to render admissible the result of a blood alcohol test of a decedent's blood, it should appear that the blood was taken before extraneous matter had been injected into the body. In *People v Koval*, 124 N.W. 2d 274 (1963) a defendant was not advised of his statutory right to have a blood test taken, police officers claiming that they did not explain this right because the defendant was so extremely intoxicated that he would not have understood the explanation. The court, in reversing the conviction, stated that the statutory requirement to explain this right was mandatory.

26. *State v Ball*, 179 A. 2d 466 (1962).

27. Cited at footnote 19. In *State v Augur*, cited at footnote 17, the court pointed out that a motorist, by consenting to the testing of his blood does not thereby waive all of his rights, and is entitled to insist that all the essential requirements of statutes dealing with the testing of blood in connection with driving while intoxicated are complied with.

28. In *State v Small*, 233 Iowa 1280, 11 N.W. 2d 377 (1943) defendant, while in jail charged with operating a motor vehicle while intoxicated, consented to taking a blood test after a physician told him that he (the physician) was convinced the defendant was intoxicated, that he would so testify, and a blood analysis would either confirm or deny his opinion. The defendant thereupon consented, but, on his trial, claimed that his consent was obtained under duress. The court rejected this contention. Moreover, the court pointed out that in Iowa, evidence of the fact that a defendant refused to submit to a blood test might, under proper instructions, be considered by the jury.

29. Vehicle and Traffic Law, secs 1192-1194.

30. 11 N.Y. 2d 58, 226 N.Y.S. 2d 403 (1962).

31. *Williams v Hendrickson*, 371 P. 2d 188 (1962); *Hanlon v Woodhouse*, 113 Colo. 504, 160 P. 2d 998 (1945).

32. *Thomas v Martin*, 202 F. Supp 540 (1961).

## APPENDIX E

### HYPNOSIS IN THE LAW

1. Introduction. Hypnosis defies precise definition. It is a fledgling in science despite the fact that its use antedates Mesmer, and it has probably been employed by witch doctors and medicine men over the centuries.

The current inability of scientists to define hypnosis and its effects generates legal implications in its use. Some of these implications include the possibility of claims of medical malpractice and suits alleging assault and battery, as well as the use of hypnotherapy to minimize damages in personal injury claims, and questions of the competency of memory recall in the hypnotic state as evidence in court.

2. What is Hypnosis? Although hypnosis cannot be precisely defined, it may be described as a means of creating an altered state of consciousness in a person, or an altered state of concentration. While a subject is in a hypnotic state, he may be manipulated by the hypnotist. The extent, character and result of the manipulation depend, in some degree, on the interpersonal relationships between the subject and the hypnotist, on the whole combination of being that is within the skin of the former, and on the skill of the latter.

In view of the fact that hypnosis involves an interplay between complicated human beings possessed of unmeasurable strengths and fallibilities, it will not be possible to predict the effect of hypnosis on any individual until more can be learned about the human brain and nervous systems. Thus, the use of hypnosis may carry with it an aspect of unpredictability, either in the hypnotic or post-hypnotic stages, as well as a possibility of dangerous results to the subject, either psychological, physiological, or both. Moreover, the subject may "fake" having been hypnotized, and, in some respects, he may manipulate the manipulator.

This description of hypnosis is not intended as a medical dissertation, and the dangers of brevity in any discussion of the subject are recognized. It is considered, however, that the preceding remarks are adequate to establish a framework for the legal discussion that follows.

3. Malpractice. The discussion of malpractice in Chapter IV indicates that, because of the dangers inherent in hypnotism, it should not be attempted by anyone who has not had adequate, careful and specialized training.

No cases have been found in which the malpractice of a hypnotist has been alleged, so there is no experience factor, derived from the courts, which indicates specifically how the medical standards of care would be applied to hypnotists.

Despite the absence of specific guidance, it may be assumed that, in addition to requiring a hypnotist to use proper care and skill in performing hypnosis, he would be required to perform a thorough pre-hypnotic examination of the patient. The ultimate in pre-hypnotic examinations would have the hypnotist obtain a complete case history of the potential subject. This would include not only a study of previous ailments and the sociological and psychological background of the patient, but also a medical work-up, complete with all accepted diagnostic tests and procedures.

It is conceded that, as a practical matter, a legal requirement for the "ultimate" type of pre-hypnotic examination in every case would effectively eliminate the use of hypnosis in most cases. But, in advance of court decisions, one cannot predict what degree of completeness the courts will require in the pre-hypnotic work-up.

In this connection, it may be pointed out that even the most thorough work-up will not forestall all dangerous sequelae that could result from

hypnosis, because of the unknowns in hypnosis and in human beings. A proper case history, it is true, would indicate to an experienced hypnotist whether he should forego the use of hypnosis in a particular case. Moreover, the work-up could reveal what words should not be used by a hypnotist, or the activities that should not be suggested for the subject during the manipulation stage. On the other hand, despite the most thorough work-up, the subject himself might knowingly or unwittingly fail to reveal essential facts to the hypnotist. Thus, in many cases, whether the failure of the hypnotist to do certain things could be considered ~~was~~ the causative factor behind an untoward result would be conjectural.

In the light of the foregoing, the basic protection afforded against claims of malpractice by a hypnotist lies in his having the degree of learning and exercising the degree of skill and judgment that are accepted as appropriate by fellow practitioners of hypnosis in the locality. Since unforeseen results from hypnosis may follow its use despite the most thorough prehypnotic work-up and the exercise of the greatest skill, the extent of work-up in any particular case will depend on the judgment of the hypnotist and, in any event, can be determined, judicially, only after the fact. It is not unreasonable to suppose that, in this regard, the courts will not be unreasonable in considering causation.

Turning specifically to questions of malpractice which might arise from the use of hypnosis in anesthesiology, it is recalled that hypnosis depends in great part on rapport between the hypnotist and the subject. Suppose, for example, while a patient is in a hypnotic state, rapport between him and the anesthesiologist should break down? Suppose, as a result of a breakdown of rapport, the muscle relaxation of the patient should no longer

be sufficient for the surgeon adequately to perform his tasks? Or, suppose a breakdown were to occur in a situation where, in reliance on hypnosis, a reduced amount of chemical anesthesia had been used, or none at all? Suppose, after the operation, the patient, having been merely anxious before hypnotism, should develop a serious neurosis? And, finally, when hypnosis is used in anesthesiology, how can the anesthetist be sure that the patient has been anesthetized?

The use of hypnosis in connection with the relief or substitution of psychosomatic conditions appears to require particular standards of skill and care, because manipulation of the patient in the hypnotic state will usually be more specific.

For example, from the standpoint of standards of care, the hypnotist before starting hypnotherapy for a psychosomatic condition, should make sure that the condition does not have an anatomical or neurological basis, although such a basis would not necessarily contraindicate hypnotherapy. This requires the application of a variety of medical skills in addition to psychiatry. And the hypnotist should have training that will give him an understanding of the central and autonomic nervous systems.

A psychosomatic condition is a defensive system used as a crutch by the patient. Thus, if hypnotherapy is used to remove a particular crutch, the hypnotist should know enough to be able to substitute another crutch or symptom, if necessary. If there should be an absence of symptom substitution, or if the substituted symptom should be worse than the original one, the effect

on the patient's condition could be sufficiently harmful to give rise to a suit against the hypnotist for damages.

The preceding remarks are also pertinent to the use of hypnosis to promote memory recall for the purposes of legal proceedings. It should be remembered, however, that a claim for malpractice can arise only out of a doctor-patient relationship, so that unless there is such a relationship when a hypnotist induces a hypnotic state for the purpose of memory recall, his negligence would not sustain a suit against him grounded on malpractice.

4. Assault and Battery. In anesthesiology, hypnosis is presently used primarily in the pre-anesthetic preparation of a patient to relieve his anxiety, and chemicals are used as the basic anesthetics. Hypnosis may also be used during a surgical procedure, however, either alone or in conjunction with chemical anesthetics.

The use of hypnosis to induce anesthesia is not generally known to or understood by laymen. It is questionable, therefore, whether the courts would find that consent to the use of hypnosis as an anesthetic may be implied in the physician-patient relationship, without requiring specific authorization by the patient on the basis of an informed express consent. Of course, the extent to which the procedure should be explained in advance would vary with the particular patient, but the courts might require fuller explanations than in other cases. On the other hand, since all the sequelae of the use of hypnosis in anesthesiology cannot be predicted, it would seem unreasonable to require that explanations be made in excessive detail, provided adequate pre-hypnotic precautions have been taken, and the procedures followed are not negligently performed.

The remarks relating to consent to hypnotic anesthesia are at least equally pertinent to consents to hypnotherapy in connection with psycho-

somatic conditions. Yet, the nature of hypnotherapy is such that the dangers from its use may be more profound than those possible from the use of hypnosis in anesthesiology. If this is so, it would appear that a greater degree of explanation to the patient would be necessary in order for the hypnotist to establish that, in any particular case, the consent to hypnotherapy was "informed".

If hypnotism is to be used in connection with memory recall for the purposes of legal proceedings, the previous remarks relating to an informal consent also would be applicable. Although there is no judicial precedent that enunciates an exception, it is likely that the rules relating to informing the subject would be relaxed in a case where, for purposes of legal proceedings, the subject himself requests that he be hypnotized.

Lest the possibility of suits for assault and battery be underestimated, it is mentioned that a suit based on assault and battery may lie when a patient receives an untoward result following an unauthorized medical procedure even though the procedure was properly performed in good faith, and there is no evidence that would justify a suit based on negligence or malpractice.

5. Hypnotherapy to Minimize Damages in Personal Injury Claims. The use of hypnotherapy to relieve or correct pain or infirmities which have a psychosomatic basis presents some interesting possibilities in legal proceedings.

It is well known that infirmities and pains suffered by personal injury claimants often disappear soon after the claimants have received compensation. Although some of these infirmities and pains are psychosomatic, it usually is not possible to determine this fact prior to settlement of a claim for damages. Thus, a claimant with a psychosomatic injury or pain may obtain financial recovery based on anticipated future long-continuing suffering

which actually would disappear with the receipt of money.

The question is raised, therefore, whether, in actions based upon debilities which are psychosomatic in nature, a plaintiff should be required to submit to hypnotherapy in an attempt to remove the symptom before trial as a means of minimizing his damages. The plaintiff's objection to such a requirement might well be imagined unless he were more interested in being cured promptly than in collecting damages.

There is, however, another side to this coin, i.e., if hypnotherapy should fail to improve the claimant, the quantum of damages might be increased. Hypnotherapy would not always be successful, because a claimant, although seemingly cooperative, might be unsusceptible, or the supposed psychosomatic condition might actually be based upon an unrecognized physiological condition.

6. Hypnosis and Memory Recall in Legal Proceedings. A hypnotist can often obtain statements of recollection from a subject who is in a hypnotic state. The ease with which these statements are obtained depends, to a great extent, on the rapport between the hypnotist and the subject, as well as on the intensity of the experience to be recalled. It is known that it may be impossible to obtain recollection of a colorless experience even when the subject is in a hypnotic state. It is also known that the degree of cooperation of a subject in the hypnotic state is affected by the reaction of the subject to the hypnotist.

Assuming, therefore, that a subject should submit to hypnosis with apparent willingness, there would always be a question to what extent statements of recollection would be the result of manipulation by the hypnotist, or have been faked by the subject.

There are, of course, some checks on veracity. For example, the reaction of the subject may be inconsistent with the tone of the matter under inquiry -- a subject might show anger when anger would not be indicated. Or, in seeking a youthful recollection, the validity of the recollection could be tested against the language used in recall, e.g., a forty-year old subject asked to recall an event which took place when he was seven years old might use language similar to that used by a seven year old.

Despite the possibility of using "checks", a statement made under hypnosis or attempted hypnosis does not have that degree of verity that would justify its acceptance in court as evidence of the facts recalled. This appears to be the rule that has been adopted by those courts that have considered the question (1). On the other hand, in People v Modesto, (2) the court stated that a trained psychiatrist could be permitted to testify as to the state of mind of the defendant at the time of the alleged crime, even though her conclusion was based upon examination of the defendant under hypnosis.

In connection with the foregoing, the question arises whether, assuming a statement made under hypnosis is not admissible in court, it may be used for other purposes. In Cornell v Superior Court (3) a court directed that the attorney for a defendant in a criminal case be permitted to have the defendant hypnotized. The court indicated that although the statement of facts evoked in the hypnotic state might not be admissible in the trial of the case, the attorney could follow up the facts revealed and, possibly, obtain admissible evidence through the "leads" furnished.

Despite the foregoing, since a confession obtained through hypnosis basically is inadmissible because it is involuntary, (4) it is considered that if a prosecutor were to follow up the facts revealed in such a confession, the evidence obtained through "leads" so furnished probably would be inadmissible. In this connection, question may be raised whether a confession would be considered voluntary and admissible if it should be based on facts revealed during hypnosis but affirmed after termination of the hypnotic state.

As a final vignette concerning the impact of hypnosis in the courts, a reference is made to State v Exum (5). In this case, it was claimed that a wife, who testified in her husband's defense, had been hypnotized by the husband on three occasions. The court stated that this fact could be taken to mean that the husband had influence over her to a greater extent than usually arises in the marital relationship and that, therefore, evidence of this fact could be competent to show partiality on the part of the witness.

# NOTES

1. State v Pusch, 46 N.W. 2d 508 (1951); People v Ebanks, 117 Cal. 652, 49 P. 1049 (1897).
2. 31 Cal Rptr 225, 382 P. 2d 33 (1963). The court distinguished this case from People v Busch, 16 Cal. Rptr 898, 366 P. 2d 314 (1961) where the witness offering opinion testimony was not shown to have been a psychiatrist, and no basis was laid for showing the value of hypnosis as an analytical tool.
3. 52 Cal. 2d 99 (1959).
4. Rex v B...er, 4 D.L.R. 795 (1928).
5. 138 N.C. 9, 50 S.E. 283 (1905).

## APPENDIX F

### LIE-DETECTORS CAN LIE!

1. George Washington and the Cherry Tree (1). If George Washington were alive today, the story of the cherry tree incident could have developed as follows:

It was late afternoon of a crisp February 12th in Virginia. Mother Washington was in her dressing room debating which of thirty-two instant hair-set sprays to apply to her hair before dinner at the Custis's. The radio was turned on low, and occasionally a song broke through the advertising.

Father Washington came in, pecked his wife on her cheek, and said, "What's for dinner?"

Mother explained they were going to the Custis's, where the food was always bad but the liquor was always good, so Father started to get ready.

As he was deciding which of forty-two pre-shave lotions to use, Mother Washington said, "Father, you're going to have to do something about George. He just sawed down your favorite cherry tree with the chain saw you gave him for his birthday."

Father Washington turned to her with mouth agape and said, "No, I don't believe it."

"Well", said Mother Washington, "he told me he did."

"I still don't believe it", said Father, "but I'll speak to him right now."

Father found George in his bedroom, reading "Conquest in Europe."

George glanced up at the intrusion, but managed to say "Hi, Dad."

"George", said Father, "Mother tells me you cut down my favorite cherry tree."

"Yes, Father, I did. I cannot tell a lie."

"I can't believe it, George, I really can't."

"Well, it's true, Father. I hope you won't punish me too much."

"Punish you? Not at all. I think you're trying to protect someone else, so will you agree to take a lie-detector examination?"

"Oh, no, Father. What's the use? I tell you I cut the tree down. That's the truth."

So, the next morning, Father Washington kept George out of school and, after some persuasion, took him down to see a private investigator who ran a polygraph service. The office in which he kept his polygraph instrument was as immaculate and orderly as an operating room, and his equipment was of the best.

Father convinced George to take the examination, but George, as <sup>can</sup> ~~well~~ be understood, was still somewhat concerned, because he really had cut down the tree. And he was missing a very interesting session at school dealing with the Korean Truce Talks. But, George was a good boy, and he was determined to obey his father, no matter how hurt and annoyed he might feel.

After Father Washington told his story to the polygraph examiner, the examiner sat George down and told him about the instrument, how it worked, and explained in detail how the examination would be given. George wriggled impatiently, but listened politely. The examiner went over the questions he would ask George, and when he was satisfied that George understood what was to happen, and seemed to be relaxed, he applied the various attachments of the

polygraph instrument to George.

At the conclusion of the examination, the attachments were removed from George, and the operator took the graphic chart or record of the examination out of the machine and reviewed it. The examiner and George walked out of the room, to greet an expectant Father Washington.

"Well", said Father.

"There is a positive indication", said the examiner in formal tones, "that George may be deceiving you and that he didn't cut the tree down."

Father Washington looked at a crestfallen George and said, with a big smile, "George, I knew you were lying, and the instrument proves it. But, haven't I always told you to tell the truth?"

And George was whipped for telling a lie.

End of Story.

Far-fetched? Not at all.

In Boeche v State (2) the court said: "It is not contended that the lie detector measures or weighs the important psychological factors. Many innocent but highly sensitive persons would undoubtedly show unfavorable physical reactions, while many guilty persons, of hardened or less sensitive spirit, would register no physical indication of falsification. This the trained operators of course understand, and proceed upon the basis of a large percentage of error."

Everyone who is anyone in the lie-detector business will admit that there is a margin for error in any lie detector test. This margin is wide enough so that the results of lie-detector tests are not generally acceptable in the scientific community.

Despite this, lie-detector successes have been of great assistance to investigating authorities. As one example, it is pointed out that a person suspected of a crime may be so awed by the machine that he will confess his guilt rather than be examined. Moreover, many results have often been proved valid after independent corroborative investigation. As a result, in many segments of industry and government, prospective employees must take lie-detector tests concerning their honesty or dependability if they want to obtain employment in fiscal or other sensitive positions.

But what about the man who refuses to take the test?

In the courts, the question of using or obtaining lie-detector evidence is usually raised in criminal cases. At least one court, however, has ruled on this question in a non-criminal case which involved the refusal of employees to take lie-detector tests at the request of their employer.

In the case of Livingston and Sons, Inc. v Constance (3), Livingston, with its associated stores, found that it was suffering inventory shortages to an extent that the company's profit was being wiped out. Thefts by employees were suspected, and, after numerous efforts were made to reduce the shortages, Livingston finally insisted that all employees take a carefully regulated lie-detector test. Forty-four employees refused, and, as a result, either quit or were fired. On the employees' application for unemployment compensation, the Unemployment Compensation Board of Review found, in effect, that requiring the employees to take lie detector tests, the refusal of some employees to do so, and their subsequent separation by forced resignation or firing were not firings for good cause and that, therefore, the employees

were entitled to unemployment compensation. This was sustained on appeal in an opinion which contained the following language: "The board of review gave full consideration to the results of such a test, i.e. possible further investigation and possible criminal charges triggered by the test; almost certain firing if the test indicated possible or probable guilt; consequent effect on reputation of the employee, etc. And the board decided there was not just cause for firing an employee who refused to take his chances on a machine which had not been proved accurate enough for court use and from which the courts universally protect the worst and most hardened criminals."

2. The Fallible Lie-Detector Test. (4) Today, there are in existence, lie-detector machines that are said to be completely accurate in recording a subject's reactions. But a lie-detector machine is merely a recording device. It translates and records physiological reactions, but it cannot adjust itself to the vagaries of either the operator or the subject.

At present, therefore, it would appear that scientific rejection of lie-detector tests is not based upon inaccuracy of the machines, but is directed toward fallibility of the operator and the subject as well as to the query whether the test questions are sound.

In connection with any test to be given, it is obvious that the operator should be thoroughly familiar with the workings and limitations of the machine itself. Moreover, since tests are based upon the psychological implications of facts that arise within the framework of a police or other investigation, the operator not only should be well educated and trained in psychology but also should have an extended experience in investigative work to aid him in framing meaningful questions.

Actually, the subject himself is the most important factor in a lie-detector test, because his emotional condition influences its validity. Thus, it is because subjects are only human that the greatest chances for error arise in the administration of tests. This is true even when subjects are cooperative. Even though it is possible to have a perfect machine, a perfect operator and a perfect test, it is impossible to have a perfect subject.

The mere prospect of taking a lie-detector test will trigger a new set of emotional reactions in a subject. The guilty person may fear that a test will reveal his guilt; the innocent person may not only fear that he will react in a way that will falsely indicate guilt, but he may also be in a resentful mood because of a feeling that he has been wrongfully suspected.

A person who is innocent of the crime being investigated, but who has committed another crime of which he is not suspected, might fear that the test will reveal his commission of the other crime. Moreover, an innocent subject might have unconscious feelings of guilt about a person or incident, whether or not related to the crime being investigated, which might lead the polygraph to reflect that he is lying about the crime. In addition, a subject might have an unknown illness, mental or physical, that would influence his reactions, or he might be a pathological liar, or he might try to "beat" the machine, or he might be aroused by resentment at what he considers to have been improper treatment by the investigating authorities. (The technique of reviewing questions with the subject prior to the examination was developed in order to avoid such pit-falls).

Some of these factors may, of course, be neutralized to some degree by the operator, in the course of his pre-test conversations with the subject.

But, it can never be shown that a subject has not been emotionally influenced by factors not germane to the test.

This negative approach to lie-detector tests is deliberate. It points up reasons why, from a scientific standpoint, results of lie-detector tests are not presently admissible in criminal proceedings, in the absence of stipulation, despite the fact that absolute infallibility is not required for the admissibility of scientific evidence. (5)

3. The Courts Suspect Lie-Detectors. It is the rule in criminal trials in the United States that in the absence of stipulation, lie-detector test results are not admissible in evidence when offered to prove or disprove whether the defendant is guilty of the crime charged. (6) This rule has been extended so that inferential reference to the results of a lie-detector test is prohibited (7), a defendant may not introduce evidence of his willingness to take a lie-detector test (8), and the prosecution may not show either directly (9) or indirectly (10) a defendant's refusal to take a lie-detector test. (11) Moreover, the results of a lie-detector test are not admissible before a Grand Jury (12).

In the first lie-detector case reported in this country, Frye v United States (13), in 1923, the defendant alleged error in the trial court's refusal to allow an expert to testify to the results of a test to which defendant had submitted. In sustaining the refusal, the court said:

"Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing

from which the deduction is made must be sufficiently established to have gained particular acceptance in the particular field in which it belongs.

"We think the systolic blood pressure deception test has not yet gained such standing and scientific recognition among physiological and psychological authorities as would justify the courts in admitting expert testimony deduced from the discovery, development and experiments thus far made."

Ten years later, the Supreme Court of Wisconsin stated (14): "We are not satisfied that this instrument, during the ten years that have elapsed since the decision in the Frye Case, has progressed from the experimental to the demonstrable stage."

In People v Forte (15), the court said, regarding a move in the trial court by defendant's attorney for the reopening of the case after completion of the trial, so as to permit the defendant to undergo a lie-detector test:

"We cannot take judicial notice that this instrument is or is not effective for the purpose of determining the truth. Can it be depended on to operate with complete success on persons of varying emotional stability? The record is devoid of evidence tending to show a general scientific recognition that the pathometer possesses efficacy. Evidence relating to handwriting, finger printing and ballistics is recognized by experts as possessing such value that reasonable certainty can follow from such tests. Until such a fact, if it be a fact is demonstrated by qualified experts in respect to the 'lie detector', we cannot hold as a matter of law that error was committed in refusing to allow defendant to experiment with it."

In People v Carter (16), the court said: "Lie-detector tests do not as

yet have enough reliability to justify the admission of expert testimony based on their results ... It therefore follows that a suspect's willingness or unwillingness to take such a test is likewise without enough probative value to justify its admission. The suspect may refuse to take the test not because he fears that it will reveal consciousness of guilt, but because it may record as a lie what is in fact the truth. A guilty suspect, on the other hand, may be willing to hazard the test in the hope that it will erroneously record innocence, knowing that even if it does not, the results cannot be used as evidence against him."

In State v Kolander, (17) the Minnesota Court held it was prejudicial error to admit the refusal of the defendant to submit to a lie-detector test. "The state concedes that the results of a lie-detector test would not be admissible, but contends that it may nevertheless be shown that defendant refused to take such test, since such refusal is evidence of a consciousness of guilt similar to evidence of flight. With this we cannot agree ... There was no explanation to the jury of the operation or effect of a lie detector. As a matter of fact, it was not even shown what type of test defendant had refused to submit to. The impact upon the minds of the jurors of a refusal to submit to something which they might well assume would effectively determine guilt or innocence, under these conditions, might well be more devastating than a disclosure of the results of such test, if given after a proper foundation had been laid showing how the apparatus functioned."

The willingness of a state's witness to take the test and the fact that he did so were held inadmissible in Kaminski v State (18), in an attempt to rehabilitate credibility of the witness. The Court said: "For there can be no doubt that in initiating the inquiry the prosecutor intended to leave in

the minds of the jurors the impression that because the witness Newbold had voluntarily submitted to a lie detector test prior to the time of trial he was a man of veracity and hence was telling the truth from the witness stand, no matter how inconsistent his tale might appear to be to the jurors when compared with the testimony offered by other State witnesses."

In State v Baker, (19) the defendant had been asked, on cross examination, whether he had made himself available for lie-detector tests. The court said: "We consider the question was improper. The results of such a test are inadmissible, as the state concedes ... Had a test been made, evidence of the test would be incompetent. Therefore reference to such a test, as indicated in counsel's question could have no proper purpose and could be asked only for prejudicial effect..."

In State v Anderson, (20) defendant complained of the court's refusal to permit his counsel to comment on his willingness to submit to a lie-detector test. The court said: "The right to comment on defendant's willingness or refusal to submit to such test depends on the admissibility of evidence showing such willingness or refusal. We have not had occasion to pass on this phase of the admissibility of lie-detector tests. In State v Kolander, 236 Minn. 209, 52 N.W. 2d 458, we held that it was reversible error to permit the state to show defendant's refusal to take such a test. It is almost universally held that the result of a lie-detector test is inadmissible. In those jurisdictions where the question has been considered, defendant's willingness to submit to a lie-detector test has been uniformly held inadmissible. Neither willingness nor refusal to submit to such test is admissible in evidence. It has been held that the results of a lie-detector test are inadmissible even if favorable to defendant in spite of a stipulation signed by the state and

the defendant that the results, no matter which way it turned out, could be admitted. Le Fevre v State, 242 Wis. 416, 8 N.W. 2d 288. Inasmuch as the results of such a test are inadmissible, it must follow that the refusal or willingness of a defendant to take the test is also inadmissible. The evidence itself being inadmissible, comments on the refusal to take such tests by the defendant would be improper. The court correctly held that such comments could not be made."

And, in 1961, the court said in State v Armwine, (21) "... that there is not a single reported decision where an appellate court has permitted the introduction of the results of a polygraph or lie-detector test as evidence in the absence of a sanctioning agreement or stipulation between the parties."

4. The Courts Trust Lie Detectors. The rule stated at the beginning of the preceding section contains an exception that lie-detector evidence may be admissible in court when there is a stipulation between the prosecution and the defense to admit the evidence.

Not all courts are willing to make this exception, but it has been accepted by most of the courts which have considered the point. And yet, in State v Valdez, (22), a recent case which adopted the exception, the highest court of Arizona was so impressed with established principles that, despite its desire to make "progress", it set down strict rules to guide the admissibility of lie-detector tests pursuant to stipulation. In a scholarly discussion which reviewed most of the authorities (23), the court in concluding its opinion, stated: "... We hold that polygraphs and expert testimony relating thereto are admissible upon stipulation in Arizona criminal cases. And in such cases the lie-detector evidence is admissible to corroborate

other evidence of a defendant's participation in the crime charged. If he takes the stand such evidence is admissible to corroborate or impeach his own testimony.

"The 'qualifications' are as follows:

"(1) That the county attorney, defendant and his counsel all sign a written stipulation providing for defendant's submission to the test and for the subsequent admission at trial of the graphs and the examiner's opinion thereon on behalf of either defendant or the state.

"(2) That notwithstanding the stipulation the admissibility of the test results is subject to the discretion of the trial judge, i.e. if the trial judge is not convinced that the examiner is qualified or that the test was conducted under proper conditions he may refuse to accept such evidence.

"(3) That if the graphs and examiner's opinion are offered in evidence the opposing party shall have the right to cross-examine the examiner respecting:

- a. the examiner's qualifications and training;
- b. the conditions under which the test was administered;
- c. the limitations of and possibilities for error in the technique of polygraphic interrogation; and
- d. at the discretion of the trial judge, any other matter deemed pertinent to the inquiry.

"(4) That if such evidence is admitted the trial judge should instruct the jury that the examiner's testimony does not tend to prove or disprove any element of the crime with which a defendant is charged but at most tends only to indicate that at the time of the examination defendant was not telling the truth. Further, the jury members should be instructed that it is for them to determine what corroborative weight and effect such testimony should be given."

The exception implies that a stipulation can cure objections raised by the scientific community. The exception is not consistent with what is known and what has been said about the fallibility of lie-detector tests.

The better rule, it seems, would be to make no exceptions based on stipulation.

5, Summary. The value of the lie-detector as an investigational aid is admitted. In view of the margin of error that is implicit in every test, however, the courts wisely do not admit lie-detector evidence in the absence of stipulation. It is considered, however, that admission of lie-detector evidence pursuant to stipulation is inconsistent with the reason for the rule that does not admit results in the absence of stipulation.

In view of the fallibility of lie-detector tests, a man who refuses to take a test should not be publicly branded as a criminal or a liar. He may honestly consider himself more trustworthy than the machine, and averse to playing Russian Roulette.

## NOTES

1. The term "lie-detector" is the popular designation for the polygraph machine and is used in this Appendix for that reason. The lie-detector is a mechanical device which simultaneously records changes in a person's blood pressure, pulse, respiration rate and depth, psychogalvanic skin reflex (skin resistance to electrical current) and, in some cases, muscular activity. There are several types of lie-detector machines presently on the market, but they are all geared to the proposition that lying creates emotional reactions that are transmuted into physiological manifestations that can be recorded in such a way as to reveal deception. The lie detector test consists of a series of questions put to a person who is connected to the machine, so that there is a simultaneous recording on the machine of the person's body changes as reflected by his responses to questions. The machine does not detect lies; it produces a record of the physiological by-products of the person's emotional reactions to the questions asked by the operator. The operator then examines the record of the responses shown on the polygraph (the record made of the test), and may detect whether a person is attempting to tell a lie and conceal it. For a more complete discussion, see Inbau and Reid, Lie Detection and Criminal Interrogation, third edition, The Williams & Wilkins Company, Baltimore, 1953; Inbau, Self-Incrimination, Charles C. Thomas, Publisher, Springfield, Illinois, 1950; Kidd, Police Interrogation, R.V. Basuino, New York, 1950; Lee, The Instrumental Detection of Deception - The Lie Test, Charles C. Thomas, Publisher, Springfield, Illinois, 1953; Mulbar, Interrogation, Charles C. Thomas, Publisher, Springfield, Illinois, 1951; Annotation, 23 ALR 2d 1306; Skolnick, Scientific Theory and Scientific Evidence: An Analysis of Lie Detection, 70 Yale L.J. 694; Silving, Testing of the Unconscious in Criminal Cases, 69 Harvard Law Rev. 683; Wicker, The Polygraph Truth Test and the Law of Evidence, 22 Tenn. L. Rev. 711; Kleinfeld, The Detection of Deception - A Resume, 8 Federal Bar Journal 153; Highleyman, The Deceptive Certainty of the "Lie Detector", 10 Hastings L.J. 47. See also cases and materials cited in *State v Mottram*, 184 A. 2d 225 (1962), at page 228.

2. 151 Neb. 368, 37 N.W. 2d 593 (1949).

3. 185 N.E. 2d 655 (1961).

4. See footnote 1.

5. *State v Valdez*, 371 P. 2d 894 (1962). The fallibility of lie-detector results does not, however, gainsay the value of the lie-detector as an investigational aid to develop leads (*State v Mottram*, cited at footnote 1), or as a means of inducing a confession in lieu of or after taking a test. *Commonwealth v Jones*, 341 Pa. 541, 19 A. 2d 389 (1941). In *Commonwealth v Hipple*, 333 Pa. 33, 3 A. 2d 353 (1939), the defendant orally confessed when a lie-detector was applied and he was told "you can lie to us but you cannot lie to this machine." Several hours later, he signed a full confession acknowledging his guilt. The only question raised was whether a confession obtained by trick could be used, and the court held in the affirmative. The court equated the quoted statement with "It would be better for you to tell the truth", which it said would not be objectionable. See, also, *Tyler v*

United States, 193 F. 2d 24 (1951), in which the court said: "The statement of the witness (polygraph operator) that he told the defendant that the machine indicated he was lying is not admitted as evidence of any alleged lying of the defendant, but merely as evidence bearing upon the question whether the confession was, in fact, 'voluntary'. We think the ruling was correct. This court has held the results of a lie-detector test to be inadmissible ... We do not mean to impair that ruling. But, here the circumstances are different. The evidence had a material bearing upon the conditions leading to Tyler's confessions and was relevant upon the vital question as to whether the same was voluntary".

6. State v Valdez, cited at footnote 5; State v Chang, 374 P. 2d 5 (1962); Boeche v State, 151 Neb. 368, 37 N.W. 2d 593 (1949); Commonwealth v Fatalo, 191 N.E. 2d 479 (1963). In People v Kenny, 167 Misc. 51, 3 N.Y.S. 2d 348 (1938), the court admitted expert testimony concerning a lie-detector test, over objection, but, in the light of People v Forte, 279 N.Y. 204, 18 N.E. 2d 31 (1938), this is an isolated case which does not express the New York rule, and has never been followed in any state.

7. People v Wochnick, 98 Cal. App. 2d 124, 219 P. 2d 70 (1950).

8. Commonwealth v Saunders, 386 Pa. 149, 125 A. 2d 442 (1956); State v Bohner, 210 Wis. 651, 246 N.W. 314 (1933); State v Perlin, 268 Wis 529, 68 N.W. 2d 32 (1954); People v Becker, 300 Mich. 562, 2 N.W. 2d 503 (1942); Marable v State, 203 Tenn. 440, 313 S.W. 2d 451 (1958); Hayes v State, 292 P. 2d 442 (1956); State v Mottram, cited at footnote 1.

9. State v Kolander, 236 Minn. 209, 52 N.W. 2d 458 (1952).

10. People v Carter, 48 Cal. 2d 737, 312 P. 2d 665 (1957).

11. But, see State v Sheppard, 100 Ohio App. 345, 128 N.E. 2d 471 (1955) and Rank v State, 373 P. 2d 734 (1962). In the Sheppard case, where a witness was involved, the court said, probably treating the matter as harmless error: "'Did you, Mr. Houk, submit to a lie detector test?' to which he replied, over defendant's objection 'Yes'. The results of the test were not inquired about, and the simple fact that a test was made by agreement of the witness under the circumstances could not prejudice the defendant's case". In the Rank case, a prosecution witness was permitted to testify, without objection, that defendant had first stated he was willing to take a polygraph examination and later stated that his attorney had advised him not to do so. The defendant's counsel thoroughly cross-examined the witness on this point and, in fact, went into the matter on cross-examination in greater detail than did the prosecutor on direct. The defendant claimed, on appeal, that since it is prejudicial error to admit evidence of refusal to submit to the test, failure of the defendant to have objected could not be considered waiver. The court, holding there had been a waiver, said: "We need not determine questions relating to the admissibility of lie-detector evidence, for we find here a clear case of waiver of any error that might have occurred ... Rank's refusal to take the polygraph examination was exposed

to the jury by his own counsel with an emphasis far greater than that produced by the prosecution. He examined every aspect of the situation, and then after the verdict was returned made the point for the first time that what he had brought so forcibly to the jury's attention was prejudicial to his client's interests. During the trial Bank had presumably taken the position that to explore the subject in detail would be advantageous to his cause. In this court he adopts the totally inconsistent position that he has suffered a grave disadvantage. We hold he is bound by the choice he first made in the court below. He has waived any error that might otherwise have occurred when testimony regarding the polygraph was first brought into the case by a state witness."

12. *People v Dobler*, 29 Misc. 2d 481, 215 N.Y.S. 2d 313 (1961).

13. 293 F. 1013 (1923).

14. *State v Bohner*, cited at footnote 8.

15. Cited at footnote 5. This language was quoted with approval in *People v Brownsky*, 228 N.Y.S. 2d 476 (1962), a case dealing with narcoanalysis. On the subject of narcoanalysis and truth serums see, also, *Lindsey v United States*, 237 F. 2d 893 (1956), *Orange v Commonwealth*, 191 Va. 423, 61 S.E. 2d 267 (1950) and *People v Ford*, 304 N.Y. 679, 107 N.E. 2d 595 (1952).

16. Cited at footnote 10.

17. 236 Minn. 209, 52 N.W. 2d 458 (1952).

18. 63 St. 2d 339 (1953).

19. 114 N.W. 2d 426 (1962).

20. 113 N.W. 2d 4 (1962).

21. 67 N.J. Super. 483, 171 A. 2d 124 (1961).

22. Cited at footnote 5.

23. Both pro and con.

## APPENDIX G

### FORENSIC PATHOLOGY AND THE LAW

1. Autopsies. The rules relating to autopsies in the Army, Navy and the Air Force are substantially the same, although, where deceased members of the Armed Forces are concerned, the authority to perform autopsies in the Army and Air Force is broader than that in the Navy.

Under appropriate regulations, (1) the commander of a military medical facility may authorize an autopsy to be performed on the remains of a member of the Army or Air Force who dies in the military service, when an autopsy is considered necessary in order to determine the true cause of death, or to secure information for the completion of military records. This broad authority could, conceivably, result in an autopsy in every case. As regards Navy and Marine Corps personnel who die in the service, however, the performance of an autopsy is basically limited to cases when death occurs under unnatural or suspicious circumstances, or where there is reason to believe that the cause of death might constitute a menace to public health, or when the cause of death is unknown. In any event -- and this applies to all services -- an autopsy is mandatory when death occurs to a member while he is serving as an aircrew member in a military aircraft.

In none of the cases just mentioned is it necessary to obtain consent of the surviving spouse or next of kin to the performance of an autopsy. But it should be noted that in some cases where a service member dies outside a military reservation, the local medical examiner or coroner may have the first right to perform an autopsy. Parenthetically, however, even in a case where the medical examiner or coroner might have this first right, he might, because of lack of his own facilities, turn to the military pathologist

to perform the autopsy -- or he might waive his right because of lack of interest in the particular death.

As regards autopsies on civilians, it is the general rule that an autopsy may be performed by the military on a civilian or retired military person who dies in a military treatment facility or on a military reservation only after the consent of the spouse or other next of kin has been obtained. There are some exceptional cases that could arise either in the United States or in foreign countries when consent to autopsy a civilian or retired person would not be required, but this would depend on purely local rules or laws. One aspect of this is, however, <sup>that</sup> consent is not necessary before an autopsy may be performed by the Army on a civilian or retired military person who is found dead on an Army reservation over which the United States has exclusive jurisdiction. But, questions of jurisdiction, exclusive or otherwise, are matters for interpretation by lawyers.

When a consent to autopsy is required, it should be obtained in writing on Standard Form 523 (Clinical Record - Authorization for Post Mortem Examination). In view of the fact that the various jurisdictions are not uniform in defining who is the proper next of kin to give consent to an autopsy, the local legal officer should be asked for an interpretation, if necessary.

Standard Form 523 must also be filled out even when consent to an autopsy is not required. In such a case, however, the applicable law, regulation or even treaty or international agreement must be cited on the form as authority.

A consent to an autopsy may be limited in scope. Therefore, the pathologist who is to perform an autopsy should read the consent form before he proceeds,

and should not go beyond the scope of the consent.

When an autopsy is performed under military auspices -- and this also applies in civilian life -- the autopsy should be thorough, and the protocol should be clearly and completely prepared. These things cannot be over-emphasized, because, very often, substantial legal rights of survivors depend on the results of autopsies.

The results of autopsies may affect the rights of survivors to various government benefits or private financial gains depending upon whether the results show death from a service-connected disability or occurrence, or as having occurred in the line of duty, or as having resulted from an accident or in the natural course of a disease.

Thus, when a pathologist certifies the cause of death in any case he should be sure he is right. If he cannot tell the cause of death, he should not be afraid to admit it. Stating the wrong cause of death when the true cause of death is unknown may make some people feel the pathologist is infallible, and it may help his ego, but it may also deprive survivors of benefits to which they are entitled. Previous mention of financial benefits may possibly appear to be overemphasizing Government benefits, as distinguished from benefits from civilian sources. But, benefits from civilian sources, such as life insurance policies, can be just as important, if not more so, than Government benefits, in some cases.

One, among many aspects of this would involve the question that could arise under a life insurance policy providing for double indemnity in the event of accidental death. Whether a death was accidental or not could involve a lot of money.

2. The Autopsy Protocol. It is most important to prepare a thorough, complete and comprehensive protocol in every case. In some cases, protocols may be important sources of information in later years. As an example, of this, it is sufficient to refer to malpractice suits against the government, where complaints allege that patients died through the negligence of Government medical personnel.

These suits are often instituted over a year after death and the autopsy, but, in the preparation of the medical aspects of the case in The Surgeon General's office, it often is necessary to refer to the autopsy protocol. In view of the fact that the pathologist who performed the autopsy or prepared the protocol may not be readily available to discuss the case, review of the protocol is limited by the language furnished.

Protocols are also referred to in claims for the correction of military records, and in other administrative proceedings where the cause of death of a service member comes up for review.

If the protocol is inadequate, the reviewer will be handicapped. So, when a protocol is prepared, it should be a thorough, literate job. As an additional facet, in many of the cases, protocols are referred to the Armed Forces Institute of Pathology for review, and such reviews are important to the reputation of the pathologist who prepared the protocols.

Up to this time, <sup>we have</sup> ~~I've~~ been discussing autopsies, but, ~~as you know,~~ pathologists are also interested in the living. When we speak of pathology and the living, <sup>it is</sup> ~~this~~ more or less accurate to refer to the pathologist as a doctor's doctor. In this area, the pathologist is out of the autopsy room, and works in his laboratory.

3. The Laboratory. By working in a laboratory away from the autopsy room, a pathologist does not avoid the law. He merely runs into a different type of legal problems.

One of the problems, or series of problems, arises out of serological tests. Two of these types of tests which immediately come to mind are those which concern blood grouping and blood alcohol. I needn't speak at length on the point that the correctness of these tests -- in fact any tests -- may determine serious legal consequences. The blood alcohol test may determine whether a person was drunk at the time he committed an offense under the law (2). The result of a blood grouping test may be vital evidence in such matters as establishing the identity of a person, or ruling out a claim of paternity in a bastardy case.

4. The Witness. The possible legal consequences just mentioned are a reminder that pathologists may be called upon to testify as witnesses in court. This is true not only in cases that involve autopsy findings, but also in cases where tests on live persons are made in connection with legal proceedings, such as the serological tests mentioned.

Thus, the pathologist should learn how to be a witness in court, and he must also know the rules that apply to preserving evidence and establishing a chain of custody of the evidence.

Without going into great detail on this subject, it is pointed out that where pathological tests are involved, and it will be necessary to testify as to the results in court, it is important to be able to establish in court that the sample tested came from the person from whose body the sample is alleged to have come. This means that in every stage of transfer of a

blood sample, as an illustration, the sample must be properly labelled or identified, and a record should be made of who handled it, transferred it, tested it, and had custody of it. This is what was meant in previous reference to preserving evidence and establishing a chain of custody.

5. Malpractice. Under the provisions of the Federal Tort Claims Act, the Government may be held liable in damages for malpractice resulting from the negligent act or diagnosis of a military pathologist. (3) What is a negligent act or diagnosis depends on the interpretation given under the law of the state in which the diagnosis is made or the act takes place.

A prime type of error is found in the cases where there was negligence in blood grouping either because the tests were unskilled, or where there was a mix-up of samples in the laboratory and patients were transfused with the wrong blood. (4)

Another type of error involves an incorrect diagnosis by a pathologist while examining tissue. This could occur where, in the course of examining tissue from a breast tumor, the pathologist finds a malignancy where none existed and, as a result, a woman's breast is removed unnecessarily.

## NOTES

1. Paragraph 9a, Army Regulations 40-2.
2. See Appendix D.
3. See Chapters IV and V.
4. See Appendix C.

APPENDIX H  
THE MEDICOLEGAL AUTOPSY  
AND THE POLICE

1. Introduction. Under the laws of the various states, the Medical Examiner, or Coroner (depending on what he is called in the jurisdiction involved) is required to perform a medicolegal autopsy when a death is caused by violence, or is sudden (while a person is apparently in good health), or when the circumstances of the death are suspicious, or if death occurs under unnatural or unusual circumstances. It will be apparent that, although some aspects of these statutes relate to purposes that do not involve criminality, many of the aspects are inextricably bound to criminal law enforcement and police work.

A police investigation into a death may be said to have the following broad purposes:

1. To identify the deceased.
2. To ascertain the time and place of death.
3. To ascertain the cause and manner of death, including the instrumentality or person causing the death.
4. To determine whether the circumstances surrounding the death involve a violation of law.

The first three purposes listed are also the purposes of a medicolegal autopsy. Although the two types of investigation have different end objectives, investigations to accomplish the three concurrent purposes often find common meeting grounds and, in some aspects, overlap.

For example, the Medical Examiner or Coroner has the responsibility for performing all tests and procedures relating to the dissection and other examination of the corpse, and the examination of clothing and other items found in the clothing and on the corpse. On the other hand, fingerprint identification and ballistic comparison of bullets found 'n the corpse are normally police matters, as is the further exploitation of leads or clues furnished as a result of the examinations performed as part of the autopsy.

In many instances, the police can achieve their objectives by means of their own investigations, and the results of the medicolegal autopsy are merely confirmatory.

In some instances, however, police cannot readily accomplish the first three purposes of their investigations without scientific assistance. On some occasions, assistance from police laboratories is all that is needed. On other occasions, because police laboratories work in limited areas, the staff and facilities of the Medical Examiner or Coroner available for performing a medicolegal autopsy can be invaluable.

The well staffed Medical Examiner or Coroner will have available on his staff, or on call as consultants, a pathologist, a toxicologist, a serologist, a radiologist, a dentist, an anthropologist and a psychiatrist, as well as representatives of various other fields of medicine and science. He will also have a laboratory, or access thereto, that includes the most modern scientific equipment. The key man in the organization is, of course, the pathologist, but he does not work alone. Moreover, all staff members, at least, should be trained in legal matters and forensics, so that in their scientific investigations they will be aware of the legal purposes to be served. In this connection, they should know how to obtain and preserve evidence and

should understand their duties and responsibilities as potential witnesses in court.

In view of the fact that the objectives of a medicolegal autopsy and a police investigation into death overlap, the Medical Examiner or Coroner will often need to know all available circumstances surrounding the death and the discovery of the corpse. Thus, he or a member of his staff can be expected to view the place where the body was found, and make his own on-the-spot investigation. Such an investigation might reveal, to scientifically oriented people, things that could be overlooked by persons not so oriented. In turn, these discoveries can often furnish ideas that will give proper thrust and direction to laboratory studies.

In many cases, the on-the-spot investigation by a doctor plays only a small part in obtaining background information which is often needed to perform a medicolegal autopsy intelligently. Information from the police is also needed. As a part of this, the police should reveal to the Medical Examiner or Coroner, particularly in the more difficult cases, their results of investigations and interviews with witnesses, relatives of the deceased, and the like.

Although the objectives of a medicolegal autopsy and a police investigation into a death have been listed in separate categories, they are not always achieved in numerical order. For example, identification of a corpse may have to await ascertainment of the manner of death, and a true evaluation of the cause and manner of death may depend upon the identity of the deceased and his social background or medical history.

Thus, the most experienced scientists using the most modern equipment cannot alone always solve police problems. There must also be leg work.

Nevertheless, scientific methods can be aids to the police, and it is considered useful to review some of the things that can be revealed by means of scientific methods applied in the medicolegal autopsy.

2. Identification of the Corpse. Although the identification of corpses is generally made through friends, relatives, identification cards found on the body, or fingerprints (if there is an earlier record or they are intact) there are times when scientific methods are necessary.

Occasionally, it becomes pertinent, in the beginning, to determine whether bones are animal or human, and this is possible by the use of chemical or microscopic tests. Age, sex, height, stature, face, and other characteristics may be determined, with the help of an anthropologist or anatomist, if sufficient skeletal remains are present. Where more than a skeleton is found, some special aids in identification may come from the comparison of postmortem X-rays of old fractures with those taken during life, the analysis of tattoos, blood grouping tests, analysis of teeth to obtain indications of age and race, and from outward usual physical characteristics, such as amputations and birthmarks. Even if mutilation or putrefaction of features has occurred to a large degree, techniques can be used to reconstruct facial characteristics by applying remaining characteristics to certain norms, and extending them.

3. The Time and Place of Death. These can often be established by witnesses, although in some cases, factors may suggest verification of witnesses' statements. There are, moreover, certain scientific measurements which can be applied.

Certain bodily changes and rate processes can assist in approximating the time of death, if otherwise unknown. These include the stage of rigor

mortis, postmortem lividity, body heat, the stage of putrefaction of the body and an analysis of the stage of digestion of foods in the stomach.

When a death is unwitnessed, verification of the place of death or where fatal injuries were inflicted may often be accomplished through scientific means. Whether a body was moved after death may sometimes be seen from the position of livor mortis on the body when the body was found, whether there are pools of blood at the scene of discovery, or the direction of flow of blood from wounds. In an apparent drowning, examination of the corpse may reveal whether the person was dead before being placed in the water or whether he drowned in fresh water or salt water. Analysis of soils or other substances on the body of the deceased or in wounds may give clues to the location of the actual death scene.

4. The Cause and Manner of Death. A postmortem examination of the body may reveal a cause of death that does not jibe with outward appearances. For example, dissection may show that a corpse with needle marks died of a brain hemorrhage, rather than morphine intoxication, or that an apparently drowned person was first strangled, or that an apparent death from carbon monoxide intoxication was not such a death.

Postmortem examination of wounds or types of wounds may indicate whether they were accidental or deliberate. For example, evidence of multiple blows on the top of a head would indicate an assault. On the other hand, abrasions or bruises on the front or back of a head might be consistent with their having been the result of the fall of a deceased who had a predisposition to heart failure. Wounds or abrasions may also reveal the type of weapon used, and may indicate whether the death was suicidal, accidental or homicidal. There are special techniques available to analyze hangings, crushing injuries, cuts, stabs,

bullet wounds, and deaths of infants. Often, wounds and the direction of entry into the body of weapons or bullets may assist in reconstructing the scene, to show whether there was murder or suicide, or the position of the person or his assailant when the death occurred.

The chemical analysis of foreign substances found on or near the body or clothing of the deceased may give leads to the assailant. Paint flecks on a hit-and-run victim, for example, could be analyzed to lead to the automobile and driver involved. Blood stains, substances under the fingernails of the corpse, strands of hair or portions of another's clothing may likewise give information. Even sweat, saliva and semen may be analyzed for blood groups. Items found in or on a suspect may, after analysis, be evidence to relate him to a victim -- blood stains of a group other than that of the suspect, but corresponding to the victim's blood group would be an example.

An important aspect of the autopsy is to determine whether injuries were responsible for the death. Moreover, when there is a question of suicide or accidental death, a medical or social history of the deceased may reveal a predisposition to suicide or accident proneness.

APPENDIX I  
MALPRACTICE AND ASSAULT  
AND THE  
DRUG AMENDMENTS OF 1962

1. The Question. Do the Drug Amendments of 1962 create new federal rules of law which supersede general law and standards of customary medical practice regarding medical malpractice and consent to medical procedures?

As a basis for analysis of this question, it is pertinent to compare the patient-consent provisions of the Drug Amendments of 1962 with the Nuremberg rules and with state, <sup>and</sup> local ~~and medical~~ <sup>medical</sup> laws and regulations relating to malpractice and patient consent to medical procedures.

2. The Drug Amendments of 1962. The Drug Amendments of 1962 (1) provide that no person shall introduce or deliver for introduction into interstate commerce any new drug, without the approval of the Food and Drug Administration. (2) A request to FDA for approval of a new drug must be supported by full reports of scientific investigations made to show whether the drug is safe and effective. (3)

As a prelude to a report of investigations, however, it will be necessary to perform pharmacological and clinical testing of the new drug on human beings. In connection with this kind of testing, the law states the clinical investigators must "inform any human beings to whom such drugs, or any controls used in connection therewith, are being administered, or their representatives, that such drugs are being used for investigational purposes and will obtain the consent of such human beings or their representatives, except where they deem it not feasible or, in their professional judgment, contrary to the best interests of such human beings." (4) (Emphasis supplied)

3. The Nuremberg Rules. The Nuremberg rules are ten principles of conduct laid down for research programs dealing with experimentation on human beings. They were formulated in 1949 by the Nuremberg military tribunal in connection with trials of war criminals. Although their legal potency is not wholly clear, they have been adopted or adapted by many research institutions, as well as by the Army. (5) As regards patient consent to experimental procedures, the rules provide, in pertinent part, as follows:

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice ... and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision ... there should be made known to him the nature, duration and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity." (6)

A comparison of the language previously quoted from the Drug Amendments of 1962 and the Nuremberg rules indicates that the standards in the Drug Amendments are less restrictive on researchers than are the standards in the Nuremberg rules.

#### 4. General Law of Malpractice and Patient Consent to Medical Procedures. (7)

In accordance with the opinions of the state and federal courts, when a physician undertakes medical care, he is required to adhere to approved medical methods and procedures in general use in the community in which he practices. When two or more methods of care are acceptable in a community, the proper use of one of the methods will protect the practitioner against a claim for damages from malpractice even though an unsatisfactory result is achieved. In any case raising the question of judgment of a medical practitioner, the courts will generally grant much latitude in his favor.

This summary statement of one aspect of the law of malpractice does not envisage the right of a physician to experiment on his patient, without the informed consent of his patient or other person authorized to consent on behalf of the patient. This would probably include using a patient as a "c ontrol". Furthermore, it is questionable whether, in the absence of statutory authorization, the courts would recognize, as valid in every case, a physician's judgment to use an experimental drug or, if the patient is a "control" in an experiment, to withhold the experimental drug, without advising the patient or his authorized representative, except, perhaps, in a terminal case, where no other known or accepted drug or procedures could be available.

Mention of an "informed oonsent" brings up the general rule that even when accepted medical procedures are involved, a physician may not treat a patient without <sup>obtaining</sup> an informed consent given by or on behalf of the patient except, perhaps, under certain emergency conditions. Otherwise, the physician may be held liable in damages for assault. According to the decided cases, a patient generally should be informed of the risks involved in a proposed

procedures before he is asked to consent to it. This is, of course, an area requiring judgment and discretion on the part of the physician, for, in some cases, telling the patient too much might be worse than telling the patient too little. This has been well considered in Salgo v Leland-Stanford Trustees, (8) where it was said:

"A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise, the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative causes of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming the patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental condition is important and in certain cases may be crucial, and that in discussing the element of risk, a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent ..."

The Salgo case and other reported cases dealing with informed consent and the discretion or judgment of a physician in informing his patient, have generally been concerned with problems involving accepted medical procedures.

Accordingly, they give only casual guidance for cases which might involve experimental drugs. Some assistance in this regard may be derived, however, from two cases which dealt with novel, though medically accepted, procedures. Thus, in Natanson v Kline, (9) which was concerned with the use of Cobalt 60 radiation treatment, and in Mitchell v Robinson, (10) which involved insulin shock therapy, the courts indicated that, when new medical procedures are contemplated, patients should be given fuller information than is usually given, as a basis for their <sup>obtaining</sup> consents.

Along the same lines, it is of some interest to note the following language from "Hypnosis in the Law": (11)

"The use of hypnosis to induce anesthesia is not generally known to or understood by laymen. It is questionable, therefore, whether the courts would find that consent to the use of hypnosis as an anesthetic may be implied in the physician-patient relationship, without requiring specific authorization by the patient on the basis of an informed express consent. Of course, the extent to which the procedure should be explained in advance would vary with the particular patient, but the courts might require fuller explanations than in other cases. On the other hand, since all the sequelae of the use of hypnosis in anesthesiology cannot be predicted, it would seem unreasonable to require that explanations be made in excessive detail, provided adequate prehypnotic precautions have been taken, and the procedures followed are not negligently performed.

"The remarks relating to consent to hypnotic anesthesia are at least equally applicable to consents to hypnotherapy in connection with psychosomatic conditions. Yet, the nature of hypnotherapy is such that the dangers

from its use may be more profound than those possible from the use of hypnosis in anesthesiology. If this is so, it would appear that a greater degree of explanation to the patient would be necessary in order for the hypnotist to establish that, in any particular case, the consent to hypnotherapy was 'informed'".

The foregoing brief statement of the law of malpractice and <sup>consents</sup> ~~comments~~ to medical procedures, when read with the Drug Amendments of 1962, indicates that the latter authorize greater latitude in experimentation on human beings, without their knowledge and consent, than is possible, without probable liability, under the law enunciated in the courts.

5. The AMA Position. In a report published in 1946 by the Judicial Council of the American Medical Association, (12) it was stated that, in order to conform to the ethics of the American Medical Association, it is necessary to obtain the voluntary consent of the patient on whom an experiment is to be performed, prior to performing the experiment. This has been emphasized in "Medico-Legal Forms with Legal Analysis" a pamphlet of the Law Department of the American Medical Association, copyright 1961, which contains a form (13) entitled "Authorization for Treatment with Drug under Clinical Investigation," to be signed by a patient or his authorized representative. The body of the form after leaving a blank in which to describe the symptoms of the disease to be treated, contains language that "it has been explained to me that the safety and usefulness of the drug in the treatment of the above condition are now being investigated and that the manufacturer or distributor has supplied the drug for the purpose of providing further evidence of its safety and usefulness. I voluntarily consent to treatment with the drug and release the attending physician from liability for any results that may occur."

The pamphlet further states "Generally drugs under clinical investigation should be administered only where ... the informed consent of the patient or his authorized representative has been obtained ... The voluntary participation of the patient will not excuse a deviation from the physician's obligation to exercise his best skill in rendering the care required of a reasonable practitioner ..." (Emphasis supplied).

Both the AMA position and the Drug Amendments of 1962 offer loopholes of varying sizes in the area of patient consent to the use of investigational drugs, but the Drug Amendments seem to be less rigid.

6. The Answer. The Drug Amendments of 1962 are susceptible to an interpretation that an expert, in using investigational drugs on human beings, may deviate from the Nuremberg rules, the decisions of the courts and the AMA position concerning patient consent and malpractice without fear of successful suits for damages for malpractice or assault and battery, if he is not negligent, dishonest or unethical. The wording of the statute gives strong thrust to the propositions that

a. It is the expert himself who may determine how to exercise his professional judgment and whether it is feasible to obtain a consent, informed or otherwise, and

b. The expert's determination, if made in good faith within a reasonable framework of expertise, will not be subject to attack even though others might have decided differently under the circumstances.

If this interpretation is valid, the amendments create new federal law that would take precedence over conflicting law and rules in an area subject to federal regulation by the Congress. Such an interpretation might, of

course, involve constitutional questions. It would, however, be a basis to afford a practical solution to scientific needs to use investigational drugs in cases where it <sup>otherwise</sup> would not be possible to obtain patient consent in sufficient numbers to perform meaningful tests. (14)

## NOTES

1. 76 Stat. 780 (1962) Codified in Title 21, United States Code (Supp. IV, 1963).
2. 21 U.S.C. 355(a).
3. 21 U.S.C. 355(b)(1).
4. 21 U.S.C. 355(i)(3).
5. See Army Regulations 70-25, 26 March 1962.
6. Hearings Before the Subcommittee on Reorganization and International Organizations of the Senate Committee on Government Operations, 88th Congress, 1st Session, part 3, at 1167 (1963).
7. For a more complete statement of the law of malpractice and consent to medical procedures, with citations, see "Malpractice and the Federal Tort Claims Act", The Insurance Law Journal, August 1963, and "Consent to Medical Procedures," The Insurance Law Journal, December 1963.
8. 154 Cal. App. 2d 56, 317 P. 2d 170, 181 (1957).
9. 186 Kan. 393, 350 P. 2d 1093 (1960).
10. 334 S.W. 2d 11 (Mo. 1960).
11. The Insurance Law Journal, February 1964.
12. Page 1164, op. cit. at footnote 6.
13. At page 37.
14. Types of cases in which consents might not be obtainable in sufficient numbers could include those involving double-blind experiments and placebo use in general.